

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
SARAH KATHERINE			Abell			June 25 1968			6:05 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
F	W	Aug 2 1896	82 YRS.	MONTHS DAYS		HOURS MIN.		June 25 Year 1968			6:05 PM
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH		
Jefferson Co Va			USA			WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince Georges Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Georges Island			N/A			None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md			Prince Georges			Logos			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
Bernard Payne			Sarah Katherine Payne			1755 Brown Rd					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no						Francis M Moody			3590 Brent St		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pulmonary Edema 1 Hour											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Arteriosclerotic Heart disease years											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4200											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				19 P.M.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
DAYTON O WATKINS								6-2567			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				531 Sannapolis Rd			
DAYTON O WATKINS				Bladensburg Rd							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Cremation			June 28, 1968			Ceder Hill			Suitland Prince George, Md.		
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ives Funeral Home—2847 Wilson Blvd. Arl., Va.								JUL - 1 1968		Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print) Paul Clifford Acton			2a. DATE KNOWN OF DEATH ESTIMATED MATED 6-11-68			2b. HOUR 192:00am M				
3. SEX Male	4. RACE White	5. DATE OF BIRTH 4-10-1922	6. AGE (In years last birthday) 46 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 6 Day 11 Year 68		2d. HOUR 5:12am M		
7a. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) JOINER.		12b. KIND OF BUSINESS OR INDUSTRY NAVAL AIR STA.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6719 Fairwood Road	
14. FATHER'S NAME First Middle Last JAMES C. Acton			15. MOTHER'S MAIDEN NAME First Middle Last ELSIE HALL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) W.W. II 579183635		17. INFORMANT MRS. FLORENCE HAWKINS		ADDRESS 6901 VALLEY ST. BEACON HTS MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3039 Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Acute intoxication - ethyl alcohol, DUE TO, OR AS A CONSEQUENCE OF (c) barbiturates and placidyl Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 3220										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-12-68				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JUNE 14, 1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MARYLAND				
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Maryland				25a. REC'D BY REGISTRAR DATE JUN 14 1968		25b. REGISTRAR'S SIGNATURE Judge				

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UNITED STATES DEPARTMENT OF AGRICULTURE

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or Print)			First ALPHA			Middle OMEGA			Last ADAMS			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year JUNE 30 1968			2b. HOUR 4:52 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan 14-1918		6. AGE (In years last birthday) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year JUNE 30 1968			2d. HOUR 4:52 P.M.	
7a. BIRTHPLACE (State or foreign country) Center Texas			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince Georges Md.							
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Pr. Geo Gen Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret'd US Army				12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Pr. Geo				13c. CITY OR TOWN District Heights		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7403-Lurey Pl., SE				
14. FATHER'S NAME First Middle Last James S. Adams						15. MOTHER'S MAIDEN NAME First Middle Last Lottie Halbert										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16b. SOCIAL SECURITY NO. WW II-Korea		17. INFORMANT Margarethe S. Adams						ADDRESS 7403-Lurey Pl SE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple old & new infarcts of the Heart 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arteriosclerosis												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE DAYTON O. WATKINS				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-2-68 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3318 annapolis ADDRESS (Street, city, town, or county) <u>Bledensburg Md</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 5-1968		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.				23d. LOCATION (City or Town) (County) (State) Arlington, Virginia								
24. FUNERAL DIRECTOR Simmons Bros				ADDRESS Wash DC				25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge						
26. GENERAL DIRECTOR Simmons Bros-1661-Good Hope Rd SE																

1. I have been a member of the
 2. [illegible] since [illegible]
 3. [illegible] [illegible] [illegible]

4. [illegible] [illegible] [illegible]
 5. [illegible] [illegible] [illegible]
 6. [illegible] [illegible] [illegible]

7. [illegible] [illegible] [illegible]
 8. [illegible] [illegible] [illegible]
 9. [illegible] [illegible] [illegible]

10. [illegible] [illegible] [illegible]
 11. [illegible] [illegible] [illegible]
 12. [illegible] [illegible] [illegible]

13. [illegible] [illegible] [illegible]
 14. [illegible] [illegible] [illegible]
 15. [illegible] [illegible] [illegible]

16. [illegible] [illegible] [illegible]
 17. [illegible] [illegible] [illegible]
 18. [illegible] [illegible] [illegible]

19. [illegible] [illegible] [illegible]
 20. [illegible] [illegible] [illegible]
 21. [illegible] [illegible] [illegible]
 22. [illegible] [illegible] [illegible]

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
Item #23a, Film GL03 8 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print) <u>Martha</u> First Middle Last						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 6-8-68 1968 17pm			2b. HOUR				
3. SEX <u>Female</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH <u>6-10-1892</u>		6. AGE (In years last birthday) <u>75</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <u>N.C.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Prince George's</u> Md.				
10. CITY OR TOWN OF DEATH <u>Cheverly</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince George Hospital</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Domestic</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Private Farm</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <u>Maryland</u>				13b. COUNTY <u>Prince George</u>				13c. CITY OR TOWN <u>Seat Pleasant</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>305 78th. Place</u>	
14. FATHER'S NAME <u>King Alston</u> First Middle Last						15. MOTHER'S MAIDEN NAME <u>Unknown</u> First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Rhoda Williams</u>				ADDRESS <u>Same as 3 E</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hypertensive cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 1 yr.</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443X</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>John Kehoe</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>6-9-68</u>				
EXAMINER'S NAME (Type) <u>John Kehoe MD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS (Street, city, town, or county) <u>Riverdale, Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>			23b. DATE <u>6-11-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Concord Bapt. Church</u>			23d. LOCATION (City or Town) (County) (State) <u>Henderson N.C.</u>					
24. FUNERAL DIRECTOR <u>H.S. Washington & Sons</u>						ADDRESS <u>4925 Deane Ave NE</u>			25a. REC'D BY REGISTRAR DATE <u>JUN 25 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
Item #17, Film G402 7/11/68 km					38841				
1. DECEASED-NAME (Type or print) First Middle Last Thomson G. Arnold					2a. DATE OF DEATH Month Day, Year June 22, 68			2b. HOUR M 6	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12 Jan 1897		6. AGE (In years lost birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges		Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo., Gen., Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Mail Clerk		12b. KIND OF BUSINESS OR INDUSTRY Government			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo., Hyattsville		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5308 41st Place	
14. FATHER'S NAME First Middle Last George B. Arnold			15. MOTHER'S MAIDEN NAME First Middle Last Gertrude M. Gross						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218 34 5862		17. INFORMANT Address Mrs. Ruth G. Arnold Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis, right DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 4109 Problems unrelated.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Problems unrelated.									
19a. DATE OF OPERATION 4-20-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Problems unrelated.		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-1-64 , to 6-22-68 , that (I) (we) last saw the deceased alive on 6-22-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Aaron Deitz				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.				22e. ADDRESS Hyattsville, Md.					
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial		23b. DATE 6/25/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-5. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input type="checkbox"/> Month	<input type="checkbox"/> Day	<input type="checkbox"/> Year	2b. HOUR
Lorenzo					Astorga	ESTIMATED <input checked="" type="checkbox"/>			6	22	1968	8:15 am
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR	
M	W	11/5/1912	55 YRS	MONTHS	DAYS	HOURS	MIN.	Month			Day	Year
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		6			22	1968
Cuba		Cuba		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George Hosp.			Attorney			Law			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
Virginia			Alexandria			Alexandria			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			13f. HENDERSON RD.			
Lorenzo Astorga			Rita M. Mujica			4303						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No						Maurice Astorga						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											15 min.	
Heart failure												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b)											2 yrs.	
Arteriosclerotic heart disease												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
				P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				
								City or Town				
								County				
								State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				6-22-68				
John Kehoe, M.D., Riverdale				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				
Burial				6/24/68				Columbia Gardens Cem.				
24. FUNERAL DIRECTOR				23d. LOCATION (City or Town)				23e. REC'D BY REGISTRAR				
Murphy Funeral Home, Arlington, Virginia				Arlington, Virginia				DATE JUN 25 1968				
				23f. REGISTRAR'S SIGNATURE				f Charles Judge				



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Emma		S.		Bailey	6 Month 25 Day 68 Year		12:15 P.M.		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Female	white		3-6-1878		90 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Prince George Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hyattsville		CARROLL MANOR - 4922 La Salle		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
DISTRICT OF COLUMBIA				Washington				7119 Dist. Hgts. Pkwy.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Charles				Johnson	Sarah				Chappelcar
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		NONE		Dr. E. E. E. - 4922 La Salle Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease - 5 yrs</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis - 5 yrs</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1, 1965</u> to <u>June 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Francis P. Hannan MD</u> DEGREE <u>MD</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. DATE SIGNED <u>June 25, 1968</u>									
22d. PHYSICIAN'S NAME (Type) <u>FRANCIS P. HANNAN</u> 22e. ADDRESS <u>1511-17 ST. N.W. WASH. DC</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/28/1968		St. Mary's Cemetery		Newport, Maryland			
24. FUNERAL DIRECTOR <u>ARCHART FUNERAL HOME, LA PLATA, MD</u> ADDRESS				25a. REC'D BY REGISTRAR <u>JUL - 1 1968</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A75ME (5)
10M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR
Willard			G.		B		aynard		DATE ESTI- MATED		9:40
3 SEX	4. RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	7 IF UNDER 24 HRS		8 IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR
M	Negro	5 April 1891		77 YRS	MONTHS		DAYS		Month 6 Day 7 Year 19 68		10:50
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		2d. HOUR
Delaware			U.S.A.		WIDOWED		DIVORCED		Prince George		10:50
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hosp.			Laborer			Various		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md			Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>			604 East Joppa Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Nathan			Baynard			Grace			Bostie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			WW1			217 246204			Mrs. Catherine Holmes 46 New London St (Wilm., Del.)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lacerations of brain											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Multiple skull fractures											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY?											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
<input type="checkbox"/>			9:40 AM 6 7 19 68			Pedestrian struck by car					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm street, factory office building, etc)			21f. LOCATION Street or R.F.D. No.			City or Town		
			Street			Rt. 301 1500 feet south of			County		
						Milborne Rd.			P.G. Md.		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED		
John Kehoe, M.D., Riverdale						DEPUTY MEDICAL EXAMINER			6-8-68		
23a. BURIAL, CREMATION OR REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County) (State)	
Burial			June 15, 1968		Asbury Cemetery			Odessa		Delaware	
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Loretta B. Jolley Jessup, Md.			DATE JUN 18 1968			Charles Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, unless delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) CAROL THERESE BEAUMONT			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year June 28 1968			2b HOUR 12 PM		
3 SEX F	4 RACE W	5 DATE OF BIRTH 9-13-1946	6 AGE (In years last birthday) 21 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF LATER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD June 28 1968		
7a BIRTHPLACE (State or foreign city) New London, Conn.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges		
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince Georges General		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE FLA.		13b COUNTY Dade, Miami		13c CITY OR TOWN		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 19635 Lenore Dr
14 FATHER'S NAME First Malcolm Middle Beaumont Last Beaumont			15 MOTHER'S MAIDEN NAME First Laura Middle Sarto Last Sarto					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b SOCIAL SECURITY NO -			17 INFORMANT ADDRESS Prince Georges County Police		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Surgical shock - Wounds multiple								
DUE TO, OR AS A CONSEQUENCE OF gun								
Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last Severe - Ruptured diaphragm & hernia of liver								
DUE TO, OR AS A CONSEQUENCE OF fracture skull, mandible, clavicle and pelvic bone								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION 6/29/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year June 28 68 HOUR A.M. 5:30 PM			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Car Struck Bridge		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) Highway			21f LOCATION Street or RFD No Little Pauls Run Bridge City or Town A.A. County Md State		
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dayton O Watkins			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED June 29 68		
EXAMINER'S NAME (Type) DAYTON O WATKINS			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5318 Annapolis Rd		
			ADDRESS (Street, city, town, or county) Bladensburg Md					
23a BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial			23b DATE 6-30-1968			23c NAME OF CEMETERY OR CREMATORY Miami Memorial Park		
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.,			ADDRESS 5130 Wisc. Ave.			25a REC'D BY REGISTRAR JUL - 2 1968		
N.W., Wash., D.C., 20016						25b REGISTRAR'S SIGNATURE J Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

Item #8, Film 402 7/10/68 km

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Marguerite		First		Middle		Last BELL		2a. DATE OF DEATH Month June Day 25 Year 1968		2b. HOUR 1:45 M.	
3. SEX female		4. RACE White		5. DATE OF BIRTH Oct. 23, 1894		6. AGE (In years last birthday) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges				Md.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Magnolia Gardens Nursing		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY HoMe					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Florida		13b. COUNTY Lunta		13c. CITY OR TOWN Lunta		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 875			
14. FATHER'S NAME Jacob		First		Middle		Last		15. MOTHER'S MAIDEN NAME Unknown		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 102-10-3381		17. INFORMANT Harry Bell		Husband		Address Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4121 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) GRAMM NEGATIVE SEPSIS 2 WEEKS	
(c) ARTERIO SCLEROTIC CV DISEASE 5 YEARS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
2. d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		2 f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (the hospital) attended the deceased from DEC. 1967 to 6-25-1968 , that (I) (we) last saw the deceased alive on 17 JUNE 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John Cosma		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED D. RECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) JOHN COSMA		22e. ADDRESS 3233 SUPERIOR LA. BOWIE, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/29/68		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION (City or Town) (County) (State) Queens County N. Y.					
24. FUNERAL DIRECTOR F. Gasch's Sons		Hyattsville, Maryland		25a. REC'D BY REGISTRAR JUL - 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

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VR A15ME (S)
1044 REV. 1 49

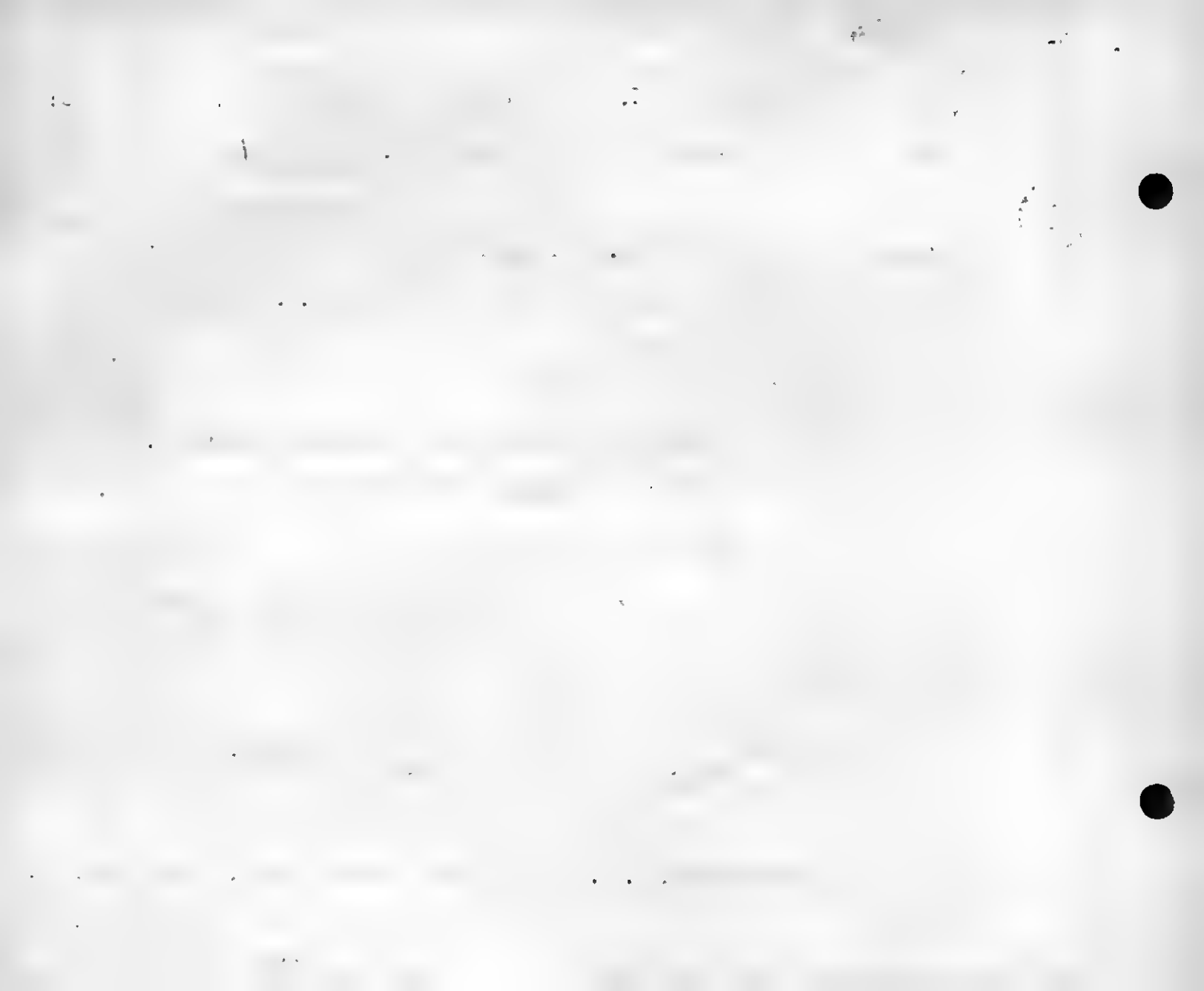
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
13a. USLA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. HOUSEHOLD LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 5318 gumparkes ASS STANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-1-68 ADDRESS (Street, city, town or county)															
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Loring I. Benedict					2a. DATE OF DEATH June Month 9 , Day 1968 Year			2b. HOUR 5:50 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH August 16, 1906		6. AGE (n years lost birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) NEBRASKA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's		Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) AGRICULTURAL AID		12b. KIND OF BUSINESS OR INDUSTRY U.S.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 65	
14. FATHER'S NAME First Middle Last IRVING ASA BENEDICT		15. MOTHER'S MAIDEN NAME First Middle Last ALIDA LORING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES W.W.II		16b. SOCIAL SECURITY NO 217 440389		17. INFORMANT MARGUERITE G. BENEDICT		Address SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with widespread metastasis. DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral hydronephrosis due to obstruction by tumor. DUE TO, OR AS A CONSEQUENCE OF (c) Cachexia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 117 x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) Aaron Deitz attended the deceased from June 9, 1968 , to June 9, 1968 , that (I) last saw the deceased alive on June 9, 1968 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.									
22b. SIGNATURE A. Deitz		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-11-68			
22d. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.		22e. ADDRESS Prince George's Plaza, Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE JUNE 12, 1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR MARYLAND			
24. FUNERAL DIRECTOR W.W. Chambers Co., Riverdale, Md.				25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE Johnas J. Jones			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Gerald A Benjamin			2a. DATE OF DEATH Month 6 Day 9 Year 1968			2b. HOUR 6:00 A. M.	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 7/14/1904		6. AGE (In years last birthday) 63 YRS.	
7a. BIRTHPLACE (State or foreign country) Louisiana		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY Unknown	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2001 Clifton St. N.W.		14. FATHER'S NAME First Herbert Middle Benjamin Last Benjamin		15. MOTHER'S MAIDEN NAME First Johanna Middle Smith Last Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 577-38-5583		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebrovascular accident 4/22/69 DUE TO, OR AS A CONSEQUENCE OF Right cerebrovascular accident with right cerebral infarction and left hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) right cerebral infarction and left hemiplegia DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day months years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic alcoholism							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that XX (this hospital) attended the deceased from 3/2/77 , 19 68 , to 6/9 , 19 68 , that XX (we) lost saw the deceased alive on 6/9 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) XXXX view the body after death.							
22b. SIGNATURE Moe Weiss				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/9/68	
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22e. ADDRESS Glenn Dale Hospital, Glenn Dale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/14/68		23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City or Town) (County) (State) Landover Md.	
24. FUNERAL DIRECTOR A.N. Horton Co 1324 you at h.w.				25a. REC'D BY REG. STRAR DATE JUN 13 1968		25b. REGISTRAR'S SIGNATURE Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR PM
Arthur			L. Bilodeau			June 25 1968			10:05M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
male		White		July 21, 1910			57 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Vermont		USA					Prince George's Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Riverdale			E. Leland Memorial			Cook			Restaurant
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Pr. Geo.		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6307 51st. Ave.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Albert Bilodeau			Leonie Letourneau						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT				
Yes			WW 11		Riverdale, Md. Eugene Leland Mem. Hosp. 4408 Queensbury Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>									1 HOUR
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>									1 DAY
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9 AUG</u> , 19 <u>67</u> , to <u>25 JUNE</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>25 JUNE</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
C. J. Houghton									26 JUNE '68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
C. J. HOUGHTON M.D.					RIVERDALE MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		6/29/68		Gate of Heaven			Silver Spring Montg. Md.		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons					Hyattsville, Md.		JUL - 2 1968		Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Amy	Middle S.	Last BLASEY	2a. DATE OF DEATH Month 6 Day 23 Year 68		2b. HOUR 1:30 ^a	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-11-83		6. AGE (In years last birthday) 85 YRS.		7. FUNDER YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) West Indies		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of work not be even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Geo		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4507 Riverdale Rd.
14. FATHER'S NAME First John		Middle Stilfox		Last Wilhelmina		15. MOTHER'S MAIDEN NAME First Robinson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578 10 2203D		17. INFORMANT Address Catherine E. Bush Same as #13		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 4567 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) with the heart - failure DUE TO, OR AS A CONSEQUENCE OF (c) in the heart - failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH for 9-10								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1950 to 1968 , that (I) (we) last saw the deceased alive on 12-24-22 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE L. H. M. A. L. H. M.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6-24-68		
22d. PHYSICIAN'S NAME (Type) L. H. M. A. L. H. M.				22e. ADDRESS 1000 ...				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/25/68		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		23d. LOCATION (City or Town) (County) (State) Laurel P. G. Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland				25a. REC'D BY REGISTRAR DATE JUN 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) THOMAS E. BOWERS			2a. DATE OF DEATH Month JUNE Day 25 Year 1968			2b. HOUR 0918 ^M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 23 June 1918		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Military Officer		12b. KIND OF BUSINESS OR INDUSTRY USAF			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Alexandria		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2101 Price's Lane	
14. FATHER'S NAME First Middle Last WILLIAM RAY BOWERS			15. MOTHER'S MAIDEN NAME First Middle Last SALLIE GARDNER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES Oct 40-Nov 68			16b. SOCIAL SECURITY NO. 245-60-7167		17. INFORMANT Mrs. Elma Leigh Bowers Address same as Wife, SALLIE G. BOWERS, #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Intracranial Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Thrombocytopenia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 24 Hours 3 Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Blastic crisis of chronic myelogenous leukemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that 10 (this hospital) attended the deceased from 15 April, 19 68 , to 25 June, 19 68 , that 4 (we) last saw the deceased alive on 25 June 19 68 and that in (My) (our) opinion death occurred on the date and hour and from the causes stated above 10 (we) (did) (2004) view the body after death									
22b. SIGNATURE William E. Palma, Capt, USAF MC MD DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 25 June 1968	
22d. PHYSICIAN'S NAME (Type) WILLIAM E. PALMA, CAPT, USAF MC					22e. ADDRESS Andrews AFB Malcolm Grow USAF Hosp, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 06/28/68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Fort Myer, Virginia		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR The Demaine Funeral Homes, Inc., Alexandria, Va.					25a. REC'D BY REGISTRAR JUL - 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mary V. Branson			2a. DATE OF DEATH Month June Day 28 Year 1968			2b. HOUR 5:30 P. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 5, 1896		6. AGE (In years last birthday) 72 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Croom		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 3434		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Croom		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER Box 3434							
14. FATHER'S NAME First John F. Middle Wilson Last			15. MOTHER'S MAIDEN NAME First Rose Middle Elizabeth Last Tayman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. ----		17. INFORMANT Josephine Halterman- Address Same as I tem #13-0-0			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction +109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 421							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11/19/62 to 6/28/68 , that (I) (we) lost the deceased alive on 6/28/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Clark Holmes, M. D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/28/68	
22d. PHYSICIAN'S NAME (Type) A. Clark Holmes, M. D.				22e. ADDRESS Upper Marlboro, Md. 20870			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/1/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City or Town) (County) (State) Upper Marlboro, PrGeo Md.	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.				25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) First Middle Last Francis Joseph Brociani						2a. DATE KNOWN OF DEATH EST. <input type="checkbox"/> Month Day Year MATED <input checked="" type="checkbox"/> 6 22 19 68			2b. HOUR MIN 9:00 PM		
3. SEX M		4. RACE W		5. DATE OF BIRTH 15 Dec., 1912		6. AGE (In years) 55 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ill.				7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George			
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George				12a. US-JAL OCCUPATION (Kind of work done during most of working life, even if ret red.) Pharmacist		12b. KIND OF BUSINESS OR INDUSTRY Drugs	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.				13b. COUNTY Prince George		13c. CITY OR TOWN Bladensburg		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4200 51st Street	
14. FATHER'S NAME First Middle Last Nazarino G. Brociani						15. MOTHER'S M A D E N NAME First Middle Last Antonina Smacchi					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. (Type given year or dates of service) WW 11		16c. SOCIAL SECURITY NO. 177 05 1348		17. INFORMANT Lena Monichelli (Sister) ADDRESS Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 11d7										(b) Arteriosclerotic heart disease	
										(c) Unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A M P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home form, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6-23-68			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town or county)											
23a. BURIAL, CREMATION, or other disposition (Specify) Burial				23b. DATE 6/27/68		23c. NAME OF CEMETERY OR CREMATORY Denison		23d. LOCATION (City or Town) Forty Fort		(County) (State) Pa.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.						ADDRESS		25a. REC'D BY REG STRAR JUL - 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

Pharmacology

Anna Smacchi

17 05 1948 Lena Montchell (Stater) Same as above

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mary			First Middle Last A. BROOKBANK			2a. DATE OF DEATH June Month 8 Day 1968 Year			2b. HOUR 8 a.m.								
3. SEX Female			4. RACE White			5. DATE OF BIRTH Oct. 3, 1884			6. AGE (In years last birthday) 85 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George Md.								
10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6001 44th Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Prince George			13c. CITY OR TOWN Hyattsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 6001 44th Avenue					
14. FATHER'S NAME First Middle Last Frederick M. Haber			15. MOTHER'S MAIDEN NAME First Middle Last Catherine Wamhoff														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) none			17. INFORMANT Address Marie E. Parish Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u> <u>15 yrs.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>C.V.A.</u>																	
19a. DATE OF OPERATION <u>7-2-68</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>C.V.A.</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>June, 1968</u> to <u>6-8, 1968</u> , that (I) (we) last saw the deceased alive on <u>6-6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>R.D. Bauer, M.D.</u>			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED DIRECTOR <input type="checkbox"/>			STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>6-8-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, M.D.</u>			22e. ADDRESS <u>2513 Buck Lodge Rd. Prince Geo</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>6/11/68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>			23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.G. Md.</u>								
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u>						ADDRESS			25a. REC'D BY REGISTRAR DATE <u>JUN 17 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Jack		First Middle Last Burton		2a. DATE OF DEATH Month Day Year June 30 1968		2b. HOUR 6:50 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 6-7-1917		6. AGE (In years last birthday) 51 YRS MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Glenn Dale (rural)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unknown		12b. KIND OF BUSINESS OR INDUSTRY Unknown	
13a. USUAL RESIDENCE (Where deceased admission) STATE D.C.		13b. COUNTY <input checked="" type="checkbox"/>		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER No fixed address		14. FATHER'S NAME First Middle Last Clarence Burton		15. MOTHER'S MAIDEN NAME First Middle Last Mary Golson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 422-16-7559		17. INFORMANT (Decedent)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 442X DUE TO, OR AS A CONSEQUENCE OF (b) Cor pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yr. 2 mo.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 500							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY; OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/27/ , 19 65 , to 6/30/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6/30/ , 19 68 , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE Moe Weiss				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED June 30, 1968	
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 5, 1968		23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) BIRMINGHAM, ALA.	
24. FUNERAL DIRECTOR W. W. Chambers		ADDRESS Con. Boardale, Md.		25a. REC'D BY REG STRAR JUL - 5 1968		25b. REG STRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

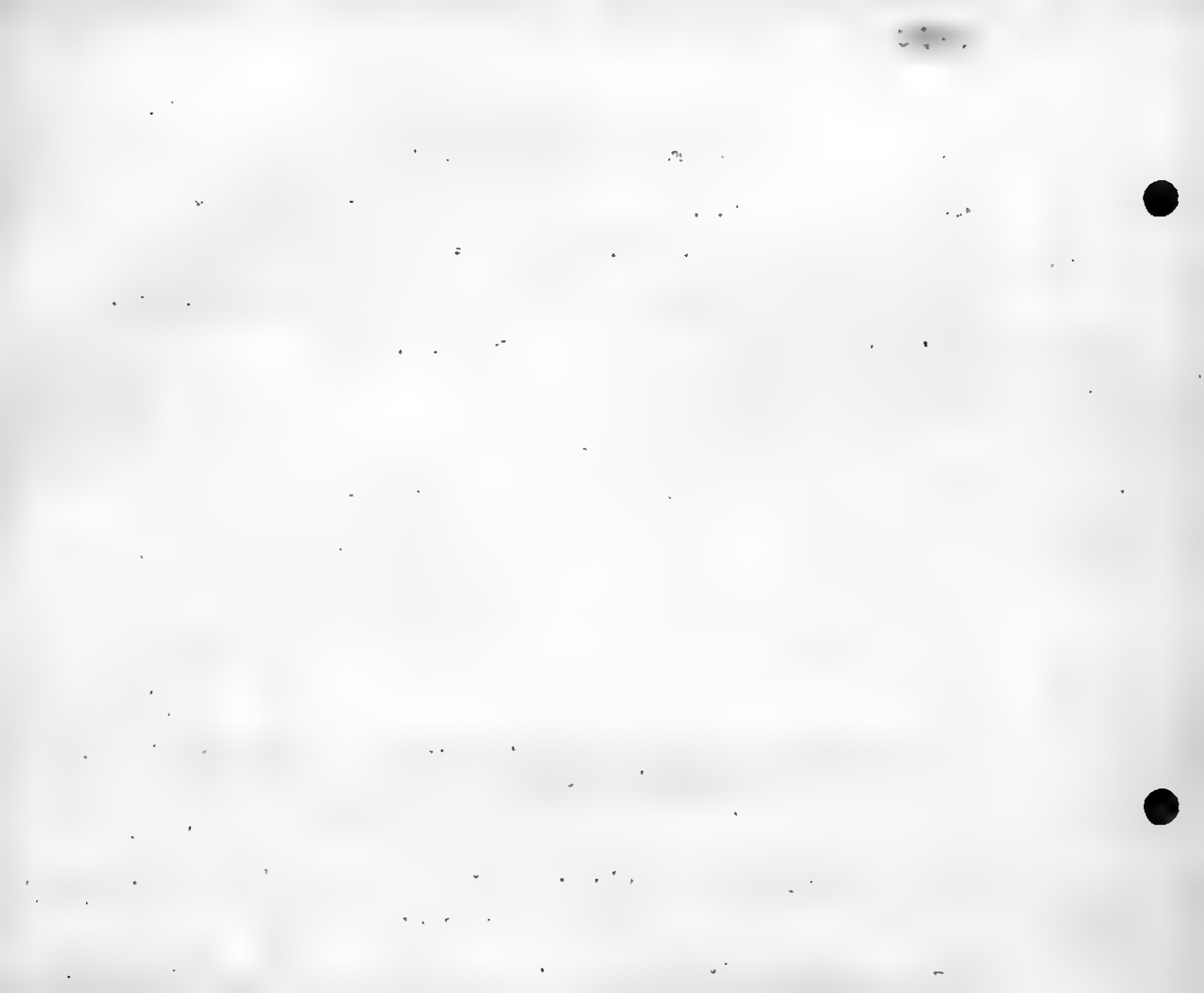
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Earl M Bywaters						Month Day Year		9:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		2c. DATE PRONOUNCED DEAD		2d. HOUR
male	white	Dec 17, 1900		67 YRS			Month Day Year		10:00 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U S A.				Prince George's Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Pro George's Hospital			Clerk		Library	
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md			Pro George's		Lanham				6706 Auburn ave.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Waverly Bywaters			Minnie Fristoe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
no			578 01 7387		Aubria E Bywaters		Lanham, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>									
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				HOUR A.M. P.M.		19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Dayton Watkins</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type) DAYTON O WATKINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7-2-68			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) 5315 Annapolis Rd. Prince Georges County Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. REGISTRAR'S SIGNATURE	
Burial		July 3, 1968		Prospect Hill Cemetery		Washington D. C.		J Charles Judge	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Md.		JUL - 5 1968			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 8 taken from Birth Certificate											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First Middle Last Baby Boy Carroll						June 23, 1968			10:30 A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasian		6/23/68		6		YRS.		2 19	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Prince George's Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER		
Maryland			Prince George's			Seabrook			3108 Lake Avenue / 9811 Franklin Ave.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Robert Carroll			Frances E. Rushing								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurely</u> 7/169 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atelectasis of lungs</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>June 23, 1968</u> , to <u>June 23, 1968</u> , that (X) (we) last saw the deceased alive on <u>June 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.											
22b. SIGNATURE						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED		
Bernardo Alvarado, M. D.									June 25, 1968		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Prince George's Gen'l Hospital, Cheverly,											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County)		
			7/13/68			Prince George's General			Cheverly, Md. Maryland		
24. FUNERAL DIRECTOR ADDRESS						1st RECORD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Harry W. Penn, Jr., Administrator						DATE JUL 16 1968			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Louise S Carter						June 23 68			7:35PM	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		White		10 June 1915		53 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna		USA				Pr. Geo., Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Pr. Geo. Gen. Hosp.			Housewife		Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Pr. Geo.		Wash. 27 D.C.		YES <input type="checkbox"/> NO <input type="checkbox"/>		33215 Oak Glen Way	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Charles T. Stiles			Reba Ringgold							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT (Husband) Address					
No			Unknown		Frederick W. Carter, Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
none										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 17, 1968</u> to <u>June 23, 1968</u> ; that (I) (we) saw the deceased alive on <u>June 23, 1968</u> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <u>Donald W. Mitchell, M.D.</u>					22c. DATE SIGNED <u>June 24, 1968</u>					
22d. PHYSICIAN'S NAME (Type) Donald W. Mitchell, M. D.					22e. ADDRESS 1746 K St., NW., Washington, D.C.					
23a. BURIAL CREMATION, REBURY (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6-26-68		Epiphany Episcopal Cem.		Forestville, Maryland				
24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. Suitland, Maryland					25a. REC'D BY REGISTRAR DATE JUN 27 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115
304 REV 10

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

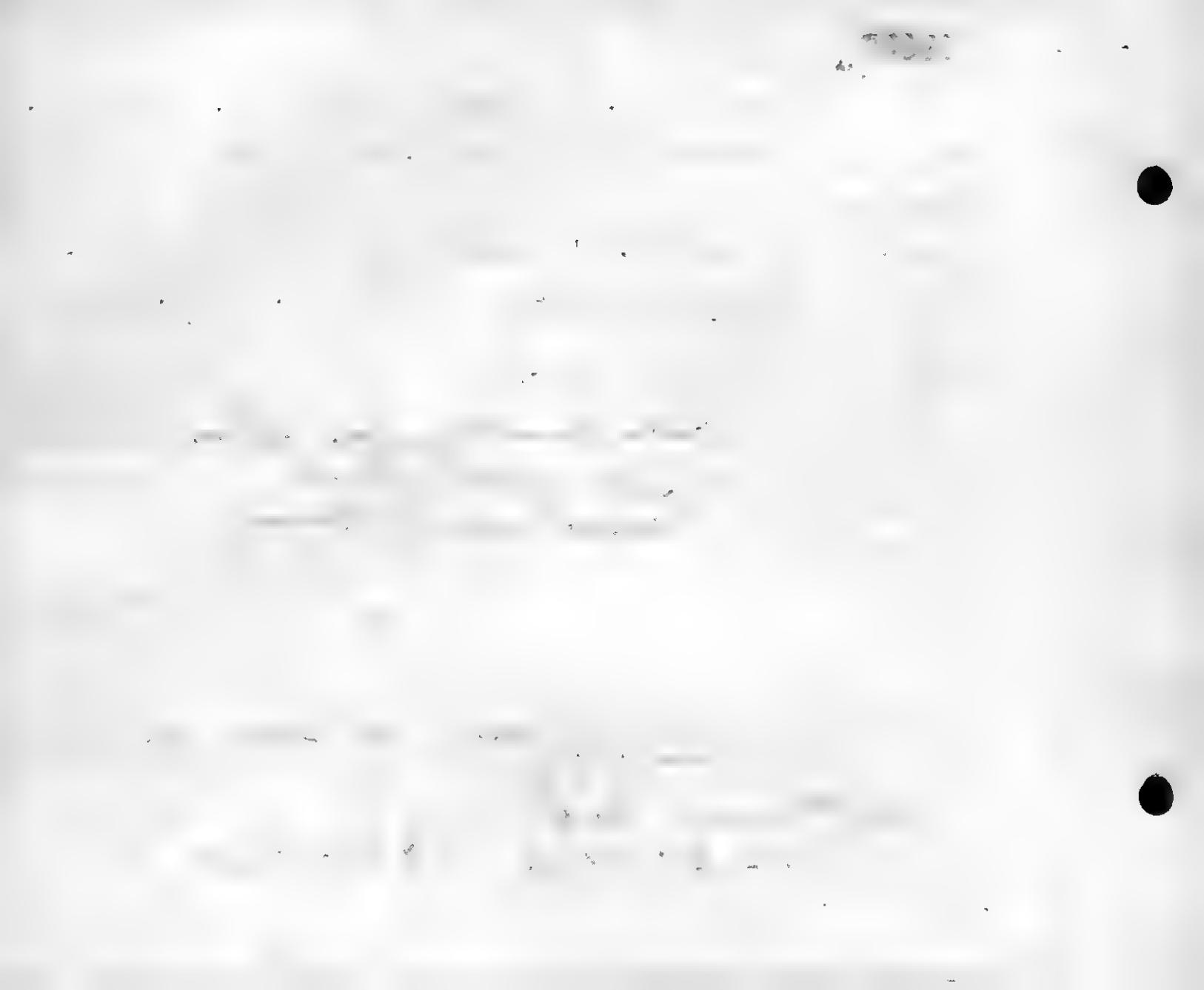
1. DECEASED NAME (Type or print) Henrietta Cistero			2a. DATE OF DEATH Month 6 Day 7 Year 1968			2b. HOUR 2:00 P.M.			
3. SEX Female		4. RACE Caucas		5. DATE OF BIRTH 8-25-1899		6. AGE (In years last birthday) 68 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) France		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eggen's Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) FLORIDA		13b. COUNTY ?		13c. CITY OR TOWN BEACH		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 24 FAIR WEATHER Lane	
14. FATHER'S NAME First ? Middle DURANT Last			15. MOTHER'S MAIDEN NAME First UNKNOWN Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 117-30-5930		17. INFORMANT ROBIN HARTMAN BOB 858 Rt 3 Annapolis Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4369 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 yr. Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cystitis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb 27, 1968 to June 7, 1968 , that (I) (we) last saw the deceased alive on June 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W.B. Sheer MD.		DEGREE MD.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED June 7, 1968			
22d. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22e. ADDRESS 6400 MARLBORO PIKE SE. WASH. D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-7-68		23c. NAME OF CEMETERY OR CREMATORY Edgar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Wittand Maryland			
24. FUNERAL DIRECTOR Robert E. Wilkins		ADDRESS 4398 Sutherland Rd		25a. REC'D BY REGISTRAR June 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
James ELWOOD Clark						June 4, 1968		10 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		May 23, 1905		63 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
WASHINGTON, D.C.		U.S.				Prince Georges				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital			FILE CLERK		SHIPPING CO		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George's		Greenbelt		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		59 E. Ridge Rd.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S M.A.DEN NAME		First	Middle	Last
ELMER					CLARK	UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not known (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT		Address		
NO			579186123			STELLA O. CLARK		SAME AS # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage, brain stem										
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arteriosclerosis										
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral vascular disease										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (the hospital) attended the deceased from MAY 1968, to JUNE 1968, that (I) (we) last saw the deceased alive on JUNE 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED								
W.L. ETIENNE		6-4-68								
22d. PHYSICIAN'S NAME (Type)		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
W.L. ETIENNE										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		6 JUNE 1968		Cedar Hill Cem		Suitland Maryland				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
W.W. Chambers Co.		Riverdale, Md.		JUN 11 1968		James Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A141
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) XAlberta			First Middle Last			2a. DATE OF DEATH Month Day Year June 17 68			2b. HOUR 5.30AM		
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH 6 June 1906			6. AGE (In years lost birthday) 62 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Pr. Geo.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. G			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Pr. Geo.			13c. CITY OR TOWN Lanham			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 9120 Crandall Road			14. FATHER'S NAME First Middle Last William A. Jackson			15. MOTHER'S MAIDEN NAME First Middle Last Annie Murray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address John T. Coates-husband-9120 Crandall		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Mesonephric Carcinoma of Pelvis DUE TO, OR AS A CONSEQUENCE OF (c) Anemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 3 yrs 4 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1992											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from 4/17 , 19 68 , to 6/17 , 19 68 , that (I) (the hospital) saw the deceased alive on 6/17/68 , and that in (my) (the hospital's) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Henry A. Wise										22c. DATE SIGNED 6/17/68	
22d. PHYSICIAN'S NAME (Type) Henry A. Wise										22e. ADDRESS Lanham, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial			23b. DATE 6/20/68			23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park			23d. LOCATION (City or Town) (County) (State) Maryland		
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Road, N.E.						25a. REC'D BY REGISTRAR DATE JUN 19 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last MARK ANTHONY COPPINS			2a. DATE OF DEATH Month Day Year June 12 1968		2b. HOUR 0332^M
3. SEX Male	4. RACE Cau	5. DATE OF BIRTH 11 June 1968		6. AGE (in years lost birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS 6 27
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Andrews AFB	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland	13b. COUNTY Prince George's		13c. CITY OR TOWN Hillside	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Lloyd Wayne Coppins			15. MOTHER'S MAIDEN NAME First Middle Last Cheryl Elaine McClure		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mother 5292 Marlboro Pike, Hillside, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 11/1X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Same DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6Hrs 27Min
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 11 June , 19 68 , to 12 June 19 68 , that (I) (we) lost saw the deceased alive on 12 June 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Paul H. Perlstein		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12 June 1968	
22d. PHYSICIAN'S NAME (Type) PAUL H. PERLSTEIN, Capt, USAF, MC		22e. ADDRESS Malcolm Grow USAF Hospital Andrews AFB, Wash DC 20331			
23a. BURIAL, CREMATION, REMOVA. (Specify)	23b. DATE 6/21/68	23c. NAME OF CEMETERY OR CREMATORY PUBLIC CREMATION		23d. LOCATION (City or Town) (County) (State) Andrews AFB, P.G.	
24. FUNERAL DIRECTOR Carl F. Aufrecht		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 20 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

Number of hauls	<i>P. setiferus</i> (%)	<i>P. setiferus</i> + <i>P. setiferus</i> + <i>P. setiferus</i> (%)	<i>P. setiferus</i> + <i>P. setiferus</i> + <i>P. setiferus</i> (%)
1	10	5	2
2	25	10	3
3	45	15	4
4	65	20	5
5	80	25	6
6	90	30	7
7	95	35	8
8	98	40	9
9	99	45	10
10	100	50	11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Archie			William Coulter Jr.			Month 6 Day 3 Year 68			6:40A M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		White		10/25/26			41 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Washington D. C.			U. S. A.						Prince George's			Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly			Prince Geo. General Hosp.			Printer			Photographer				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER				
Md			Prince George Edmonston			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4818 48th Avenue				
4. FATHER'S NAME			5. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Archie William Coulter Sr.			Myrtle I. Lowe										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
Yes			WW 11			579 28 2252			Ruth Coulter			Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple Myocardial Infarctions</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
4101													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			HOUR A.M. Month Day Year										
			P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION							
						Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1968</u> , to <u>6/2/1968</u> , that (I) (we) last saw the deceased alive on <u>6/2/68</u> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED	
<u>Dr. Robert Deitz</u>												6/3/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
Dr. Robert Deitz						Prince Geo. Plaza, Hyattsville, Md,							
23a. BURIAL, CREMATION, or other disposal (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			6/6/68			Ft. Lincoln			Colmar Manor P. G. Md.				
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons						Hyattsville, Md.			JUN 10 1968			<u>James J. Jones</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18862

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
David			Ronald			Crabbe			1971: 1:10pm M		
3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (in years last birthday)	7 UNDER 24 HRS MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	Negro	1-28-1951	17 YRS	Month 6 Day 7 Year 1968			1971: 2:34pm M				
7a. BIRTHPLACE (State or foreign country)		7b. C. T. ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
D.C.		USA				Prince George's Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's			Beltsville			5310 Brewer Road		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		
Morris Crabbe			Dorothy Greene			No			Mother Some As 3 E		
17 INFORMANT			ADDRESS			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mother			Some As 3 E			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:10pm 6-7-1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Drowned while swimming in stone quarry.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.) stone quarry, 1/2 mile north of Fairland Rd., Beltsville, Md.			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED		
John Kehoe MD			John Kehoe MD Riverdale, Md.						6-8-68		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
6-11-68			6-11-68			Lincoln Memorial			201 Highland Rd Md		
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
A.S. Washington & Sons 4925 Penn Ave NE			D.C.			DATE JUN 13 1968			Charles Judge		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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1 DECEASED NAME (Type or Print) <i>Francine</i>		First		Middle		Last <i>Curry</i>		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <i>June 28 1968</i> 2b HOUR <i>5:30 PM</i>			
3 SEX <i>F</i>	4 RACE <i>C</i>	5. DATE OF BIRTH <i>1940</i>		6. AGE (In years last birthday) <i>28</i> YRS		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>		2c DATE PRONOUNCED DEAD Month <i>June</i> Day <i>28</i> Year <i>1968</i> 2d HOUR <i>5:30 PM</i>	
7a. BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges Md</i>					
10. CITY OR TOWN OF DEATH <i>Riverdale</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Eugene Leland Memorial</i>						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		2b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before adm.) STATE <i>MD</i>		13b COUNTY <i>PRINCE GEORGES</i>		13c CITY OR TOWN <i>HYATTSVILLE</i>		3d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <i>503 Greenbush Drive Hyattsville Md</i>			
14 FATHER'S NAME <i>Willie Curry</i>		First		Middle		Last		15 MOTHER'S MAIDEN NAME <i>Eula Mae Crockett</i>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		(If yes give war or dates of service)		16b SOCIAL SECURITY NO. <i>250-56-1909</i>		17 INFORMANT <i>Richard Hugon</i>		ADDRESS <i>2121 Shusterman</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Sub-Dural Hematoma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>040</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year <i>June 27 68</i> HOUR A.M. <i>PM</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell and Struck Head</i>							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <i>Home</i>		21f LOCATION Street or R.F.D. No. <i>503 Greenbush</i> City or Town <i>Hyattsville</i> County <i>PRINCE GEORGES</i> State <i>MD</i>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b DATE SIGNED <i>6-29-68</i>	
ACTUAL SIGNATURE <i>Dayton Watkins</i>		EXAMINER'S NAME (Type) <i>DAYTON D WATKINS</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>5318 Annapolis Rd</i>		ADDRESS (Street, city, town, or county) <i>Bladensburg Md</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>7-4-1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>David Stand</i>		23d LOCATION (City or Town) <i>Lancaster</i>		(County) <i>S.C.</i>		(State)	
24 FUNERAL DIRECTOR <i>Wm. H. Hume</i>		ADDRESS <i>Fun. Home Lancaster, S.C.</i>		25a REC'D BY REGISTRAR <i>JUL - 3 1968</i>		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Patricia Ann Daniels			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 6-12-68 192:00pm		
3 SEX Female	4 RACE White	5 DATE OF BIRTH MAY 6 1941	6 AGE (In years last birthday) 27 YRS	7 UNDER 1 YEAR MONTHS _____ DAYS _____	8 IF UNDER 24 HRS HOURS _____ MIN _____
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		9 COUNTY OF DEATH Prince George's Md	
10 CITY OR TOWN OF DEATH Brandywine		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brandywine Medical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAIL CLERK	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Brandywine	
14 FATHER'S NAME ROY LEE SHIRKEY		15 MOTHER'S MAIDEN NAME VIOLA CLEM		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO UNKNOWN		17. INFORMANT ROBERT EARL DANIELS ADDRESS SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of chest 755X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 976X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 2:00pm 6-12-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot self with .22 cal. revolver	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____ same as # 13	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6-13-68	
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 15 JUNE 1968		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE MD		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND.		25a. REC'D BY REG STRAR JUN 19 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A
304 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Walton P Darwin			2a. DATE OF DEATH 6 Month 19 Day 1968 Year		2b. HOUR 9:30 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 10, 1975		6. AGE (In years last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Tenn.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DESIGNER	12b. KIND OF BUSINESS OR INDUSTRY ENGINEER	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY PRINCE GEORGE	13c. CITY OR TOWN HYATTSVILLE	13d. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8026 NEW RIGGS RD.
14. FATHER'S NAME First Middle Last JOHN W. DARWIN		15. MOTHER'S MAIDEN NAME First Middle Last LASSIE PRUETT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (1 yes give year or dates of service) NO		16b. SOCIAL SECURITY NO 578-32-4509	17. INFORMANT JOHN W. DARWIN 8026 NEW RIGGS RD. HYATTSVILLE MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 41 UREMIA DUE TO OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE 5 YEARS (b) DUE TO, OR AS A CONSEQUENCE OF PULMONARY EMPHYSEMA 10 YEARS (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5221 ARTERIOSCLEROSIS, GENERALIZED					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1962 to 19 JUNE 1968, that (I) (we) last saw the deceased alive on 17 JUNE 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J.B. Snow M.D.		DEGREE M.D.		22c. DATE SIGNED 6/19/68	
22d. PHYSICIAN'S NAME (Type) L.B. SNOW		22e. ADDRESS LANGLEY PK. MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 6/21/68	23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON CEM.		23d. LOCATION (City or Town) (County) (State) HYATTSVILLE PRINCE GEORGE, MD.	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co., 5801 CLEVELAND AVE. RIVERDALE MD.		ADDRESS		25a. REC'D BY REG. STRAR JUN 24 1968	25b. REGISTRAR'S SIGNATURE James



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 2 and 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13a, b, c Film 402 MARYLAND STATE DEPARTMENT OF HEALTH
7-25-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7a b Film 402 7 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

863

1. DECEASED NAME (Type or Print) William Davis			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 21 Year 1968			2b. HOUR 00a		
3 SEX Male	4 RACE Negro	5. DATE OF BIRTH 8-11-1912	6 AGE (In years last birthday) 55 YRS	if UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 6 Day 21 Year 1968		
7a BIRTHPLACE (State or foreign country) Wagener, S.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			Md.	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before death) Maryland, D.C. Prince George's, Bladensburg			13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 76 Randolph Pl., NW. #1	
14. FATHER'S NAME First Steven Davis Middle Last			15. MOTHER'S MAIDEN NAME First Lugenia Abney Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS Ruth Davis - 76 Randolph Pl., NW. #1				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LACERATION OF BRAIN DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) COMPOUND SKULL FRACTURE DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 11:00am 6-21-1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) STRUCK BY CRANE BOOM				
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Julian Cohen Salvage Co.		21f. LOCATION Street or RFD No 4557 Tanglewood Dr., City or Town Bladensburg, State Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-21-68
23a BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b DATE 6-25-68		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Cemetery		23d LOCATION (City or Town) (County) (State) Prince George, Md.		
24 FUNERAL DIRECTOR John T. Rhines Co. Funeral Home,				ADDRESS Wash., D. C.		25a REC'D BY REGISTRAR JUN 26 1968		25b REGISTRAR'S SIGNATURE Charles Judge

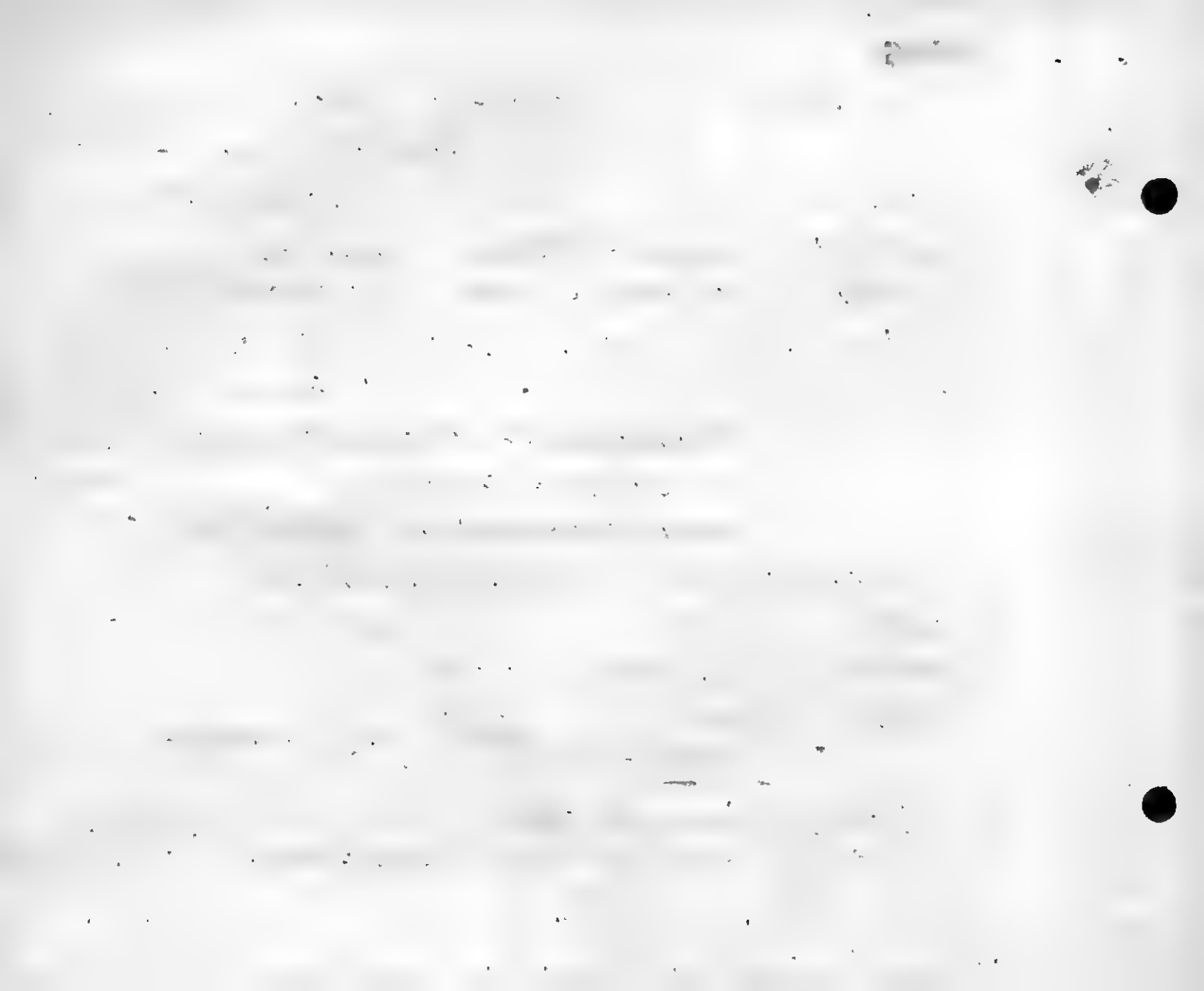
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) ELIZABETH V. DENNISON		2a. DATE OF DEATH Month JUNE Day 29 Year 1968		2b. HOUR 1:45 P.M.
3 SEX F	4. RACE W	5. DATE OF BIRTH 8/23/76	6 AGE (in years last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH PRINCE GEORGES Md.	
10. CITY OR TOWN OF DEATH CLINTON	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CLINTON COMMUNITY HOSP.	12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) Housewife	12b KIND OF BUSINESS OR INDUSTRY FARM	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.	13b COUNTY PR. GED.	13c CITY OR TOWN CLINTON	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 10407 BRANDYWINE RD.
14. FATHER'S NAME First JAMES MULLIKIN Middle Last 	15. MOTHER'S MA DEN NAME First MARY A. GODDARD Middle Last 		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)	
16b SOCIAL SECURITY NO 		17. INFORMANT Address HOSPITAL RECORDS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA - TERMINAL BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) UREMIC POISONING DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE PYELONEPHRITIS - AEROBACTER AEROGENES				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 7 DAYS 15 DAYS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GENERALIZED ARTERIOSCLEROSIS				
19a DATE OF OPERATION NONE	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO DEATH (If either, notify med. cert. examiner) NONE	21b. TIME OF INJURY HOUR A.M. NONE P.M. NONE	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) NONE		
21d INJURY OCCURRED While NONE at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) NONE	21f. LOCATION Street or R.F.D. No. City or Town County State NONE		
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 1962 , to PRESENT , that (I) (we) last saw the deceased alive on JUNE 28 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Arthur Shaver Jr. MD		22c. DATE SIGNED 6/29/68	22d. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. MD	
22e. ADDRESS 8808 BRANCH AVE, CLINTON, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 1, 68	23c. NAME OF CEMETERY OR CREMATORY Bells Church Cemetery	23d. LOCATION (City or Town) (County) (State) Camp Springs Md.	
24. FUNERAL DIRECTOR Simmons Bros		25a. REC'D BY REGISTRAR JUL - 2 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

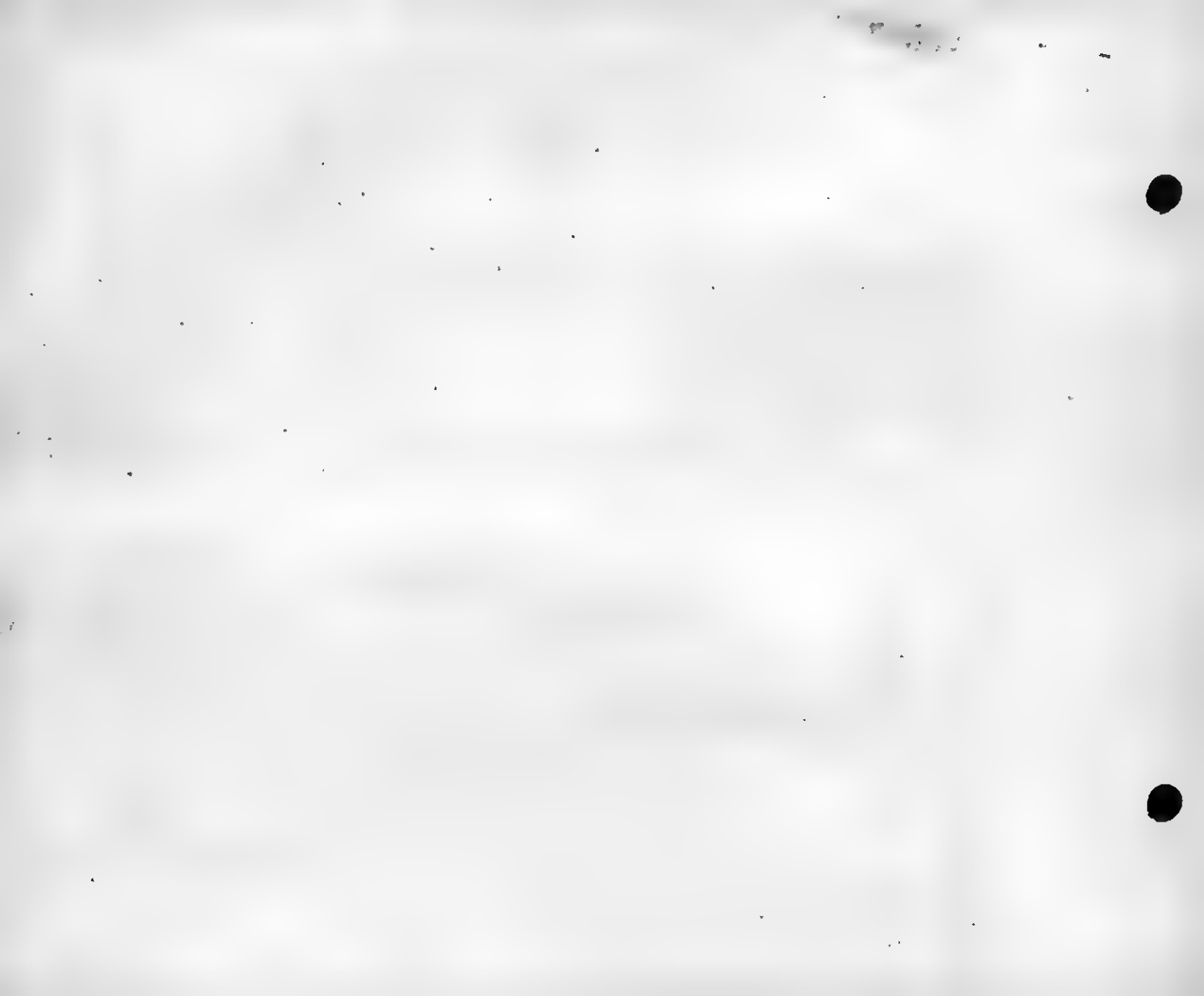


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-6. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) GALEMAN First DEXTER Last JR			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month June Day 30 Year 1968			2b. HOUR PM			2c. DATE PRONOUNCED DEAD June 30 Month June Day 30 Year 1968		
3. SEX M		4. RACE W		5. DATE OF BIRTH Jan 27 1926 YRS 42		6. AGE (In years at birthday) 42 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. F UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Indiana			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Pr George Md.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen Accounting			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Accountant			12b. KIND OF BUSINESS OR INDUSTRY Government		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md			13b. CITY OR TOWN Pr Geo Bowie			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER 123116 Millstone		
14. FATHER'S NAME First Galeman Middle Dexter Last Sr			15. MOTHER'S MAIDEN NAME First Myrtle Middle Kitch Last Bowman			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year of service) WW2			16b. SOCIAL SECURITY NO 23116		
17. INFORMANT Daisy Beatrice Dyer Bowman			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon monoxide inhalation DUE TO, OR AS A CONSEQUENCE OF suicide Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last murder (b) Carbon monoxide inhalation DUE TO, OR AS A CONSEQUENCE OF suicide (c) Carbon monoxide inhalation DUE TO, OR AS A CONSEQUENCE OF suicide			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1111		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 19 HOURS AM P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Automobile Garage			21f. LOCATION Street or R.F.D. No Home address City or Town Pr George County Pr George State Md					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dayton Watkins			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 7-2-68		
EXAMINER'S NAME (Type) DAYTON D WATKINS			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) 538 S. Main St. Pr George, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE July 5, 1968			23c. NAME OF CEMETERY OR CREMATORY NEW OAKHILL CEM			23d. LOCATION (City or town) (County) (State) PLYMOUTH INDIANA		
24. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Md.			25a. REC'D BY REGISTRAR JUL - 8 1968			25b. REGISTRAR'S SIGNATURE J Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

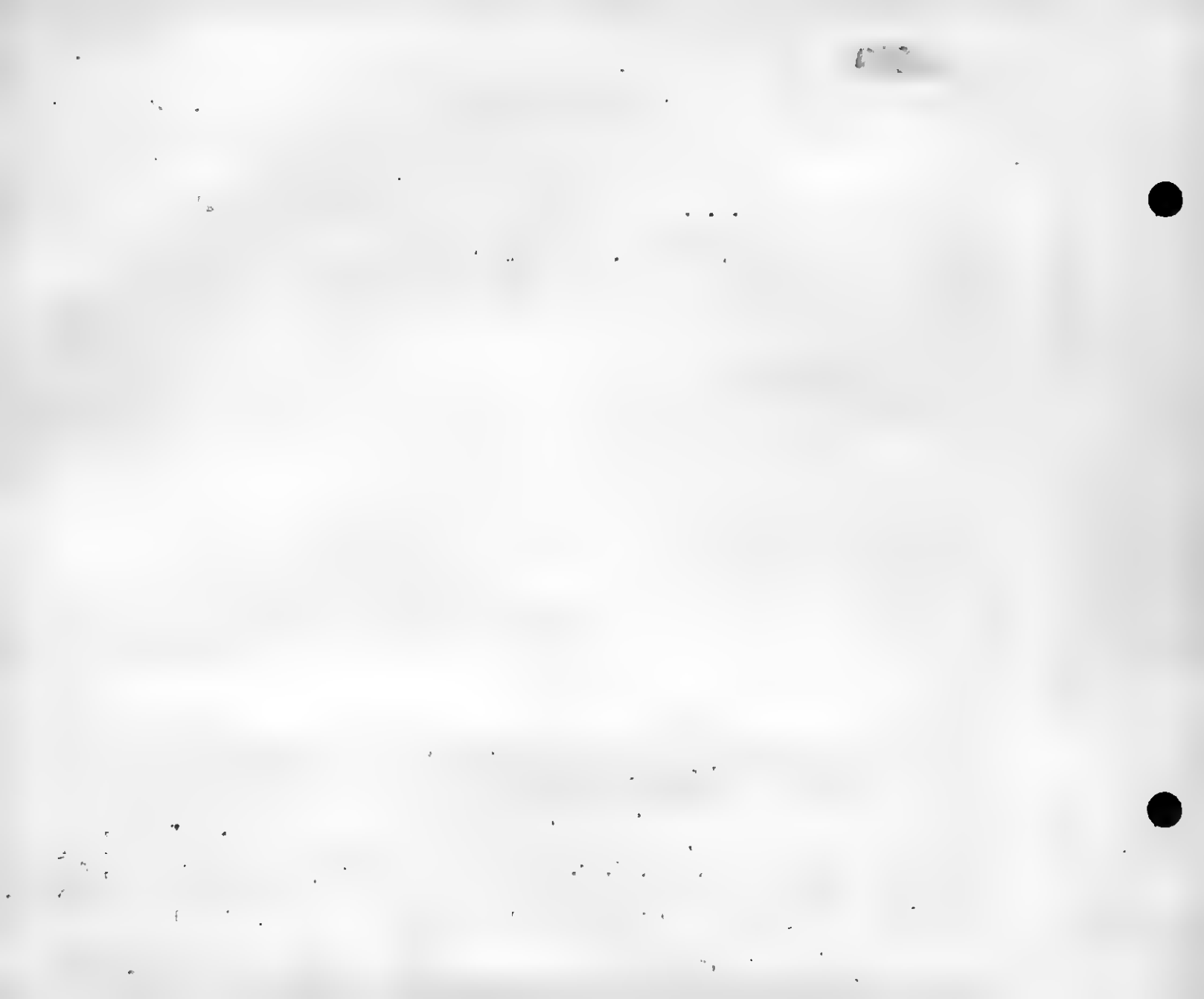
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #1, Taken from birth certif. 7 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Germaine Baby Girl Ann DILLON			2a. DATE OF DEATH 6 Month 22 Day 68 Year			2b. HOUR 8:35 A			
3. SEX F		4. RACE W		5. DATE OF BIRTH 6/22/68		6. AGE (In years last birthday) YRS. - MONTHS - DAYS - HRS. - MIN.		7. UNDER 1 YEAR MONTHS - DAYS - HRS. - MIN.	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Babam		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9512 ALCONA ST	
14. FATHER'S NAME First Middle Last Dennis Paul Dillon			15. MOTHER'S MAIDEN NAME First Middle Last Germaine A. Waddell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary embolism</u> 7769 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>immobility</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (did not) attended the deceased from 6/22/68, 19, to 6/22, 1968, that (I) (was) saw the deceased alive on 6-22-1968, and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edmond Rodriguez				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED June 22, 1968			
22d. PHYSICIAN'S NAME (Type) Edmond Rodriguez, M. D.				22e. ADDRESS 3611 Bouchard Ave. Beltsville Heights Md.					
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE 6/29/68		23c. NAME OF CEMETERY OR CREMATORY Prince George's General		23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland			
24. FUNERAL DIRECTOR WILLIAM A. PARKER, ASSOC. ADMINISTRATOR				HOSPITAL REGISTRAR DATE JUL - 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <div style="display: flex; justify-content: space-around;">BabyBoyDorsey</div>			2a. DATE OF DEATH June Month 25, Day 1968 Year		2b. HOUR 8:25 A
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH June 23, 1968		6. AGE (in years last birthday) YRS 1 MONTHS 20 DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atelectasis of lungs</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (a) (this hospital) attended the deceased from <u>June 23, 1968</u> , to <u>June 25, 1968</u> , that (a) (we) last saw the deceased alive on <u>June 25, 1968</u> , and that in (xx) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (not) view the body after death.					
22b. SIGNATURE <u>Bernardo Alvarado, M. D.</u>		22c. DATE SIGNED June 25, 1968		22d. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/13/68		23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator		23d. LOCATION (City or Town) (County) Cheverly, Maryland		23e. RECEIVED BY REGISTRAR JUL 16 1968	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08870

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Neill Winthrop Dumont			2a. DATE OF DEATH Month Day Year June 14, 1968		2b. HOUR P. 12:40
3 SEX Male	4 RACE White	5. DATE OF BIRTH Nov. 30, 1886		6. AGE (In years lost birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges Md.		
10. CITY OR TOWN OF DEATH Forestville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Forestville Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Lumber Broker	12b. KIND OF BUSINESS OR INDUSTRY Own Business		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Pr. Geo's	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 14807 Chelsea Lane	
14. FATHER'S NAME First Middle Last Cornelius Dumont		15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. ---	17. INFORMANT Address Mrs. Anita D. Wolf-Same as Item #13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Emphysema					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 10 yrs
19a. DATE OF OPERATION 4-20-61	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Emphysema	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov , 19 67 , to 14 June , 19 68 , that (I) (we) last saw the deceased alive on June 14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. B. Sasscer		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 6/14/68
22d. PHYSICIAN'S NAME (Type) R. B. Sasscer, M. D.		22e. ADDRESS Upper Marlboro, Md. 20870			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/17/68	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D.C.		
24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR JUN 19 1968	25b. REGISTRAR'S SIGNATURE J. Charles Young		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

32877

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

76

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Robin Lynn Ervin						6-12-68			19 2			00pm		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Female	White	1-20-1958	10 YRS					Month Day Year			6 12 68 6:50pm			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.					
Wash., D.C.		USA					Prince George's							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Clinton			6532 Hallon Street			Student								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Prince George's			Clinton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6532 Hallon Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Larry P. Ervin			Joyce F. Arbogast											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Father)			ADDRESS					
NO			None			Larry P. Ervin,			Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning														
764X DUE TO, OR AS A CONSEQUENCE OF And Strangulation														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
764X														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
				2:00 PM 6-12-68				Attacked by assailant.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No City or Town County State						
				Home				same as #13						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED						
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				6-13-68						
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)						
Riverdale, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)		
BURIAL				6-17-68				Cedar Hill Cemetery				Suitland, Maryland		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
Wilhelm Funeral Home				DATE JUN 19 1968				J. Charles Judge						
4308 Suitland RD. SE, Washington, D.C.														

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #443. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

VR A15ME (5)
10M REV 1/68

44

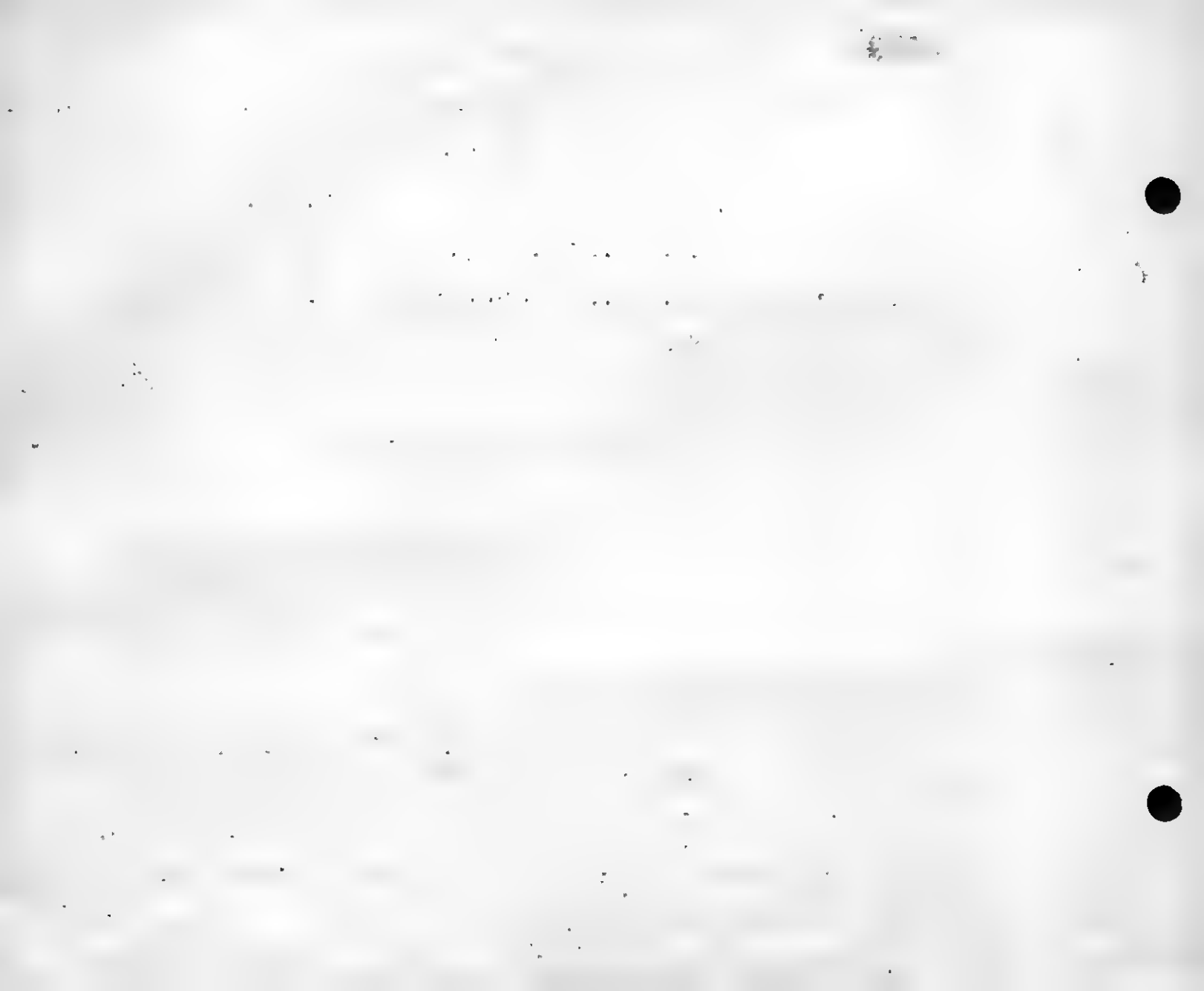
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Eddie			First Middle Last Farrington			2a. DATE OF DEATH Month Day Year June 22 68			2b. HOUR 6,35 PM		
3. SEX Male			4. RACE Negro			5. DATE OF BIRTH Feb. 29, 1899			6. AGE (In years last birthday) 69 YRS		
7a. BIRTHPLACE (State or foreign country) D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Pr. Geo. Md.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo., Gen., Hosp.,			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Pr. Geo.			13c. CITY OR TOWN Seat Pleasant			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 905 67th Avenue			14. FATHER'S NAME First Middle Last John Farrington			15. MOTHER'S MAIDEN NAME First Middle Last Ann Campbell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. no			17. INFORMANT Elcaner Z. Bennett			Address Seat Pleasant + 905-67th Ave. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4-21-7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that xx (this hospital) attended the deceased from June 7, 1968 , to June 22, 1968 , that xx (we) last saw the deceased alive on June 22, 1968 , and that in xx (our) opinion death occurred on the date and hour and from the causes stated above. xx (we) (did) not view the body after death.											
22b. SIGNATURE Leon Levitsky, M. D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED June 24, 1968		
22d. PHYSICIAN'S NAME (Type) Leon Levitsky, M. D.						22e. ADDRESS Prince George's General Hospital, Cheverly					
23a. (BURIAL) CREMATION, REMOVAL (Specify)			23b. DATE 6-29-68			23c. NAME OF CEMETERY OR CREMATORY Church Cemetery			23d. LOCATION (City or town) (County) Burlington, N.C.		
24. FUNERAL DIRECTOR Crouch Funeral Home						ADDRESS Wash. D.C. 5501-8, St. N.W.			25a. REC'D BY REGISTRAR JUN 27 1968		
						25b. REGISTRAR'S SIGNATURE Charles Judge					



CERTIFICATE OF DEATH

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, and 6 and 7 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George Co Md MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Md b. COUNTY Howard			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel Md				c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sanage	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Laurel General Hospital				d STREET ADDRESS 312 Sanage Guilford Rd		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Catherine Middle Naomi Last Feeser				4 DATE OF DEATH Month 6 Day 3 Year 1968			
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/5/1921		9 AGE (In years last birthday) 47 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawrence		10b KIND OF BUSINESS OR INDUSTRY home		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Oscar Phaylan Frity				14 MOTHER'S MAIDEN NAME Ann M. Shuey			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 216-14-6789		17 INFORMANT Address Marion Feeser - home			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RENAL ARTERIAL INSUFFICIENCY DUE TO (b) ARTERIO SCLEROSIS, GENERAL DUE TO (c) DIABETES MELLITUS, IMMATURE ONSET-TYPE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last LIFELONG							INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GANGRENE of FEET, BILATERAL							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 MAY , 19 68 , to 3 JUNE , 19 68 , that (I) (we) last saw the deceased alive on 28 MAY , 19 68 , and that death occurred at 12 AM , from causes and on the date stated above.							
22a. SIGNATURE J. Richard Compton M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6 June 68	
22c. PHYSICIAN'S NAME (Type) J. RICHARD COMPTON				22d. ADDRESS 612 MAIN ST, LAUREL, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-6-68		23c. NAME OF CEMETERY OR CREMATORY Sanage Cem		23d. LOCATION (City or Town) (County) (State) Sanage Md	
24. FUNERAL DIRECTOR Alc With Carolan, Laurel Md				25a. REC'D BY REGISTRAR DATE JUN 12 1968		25b. REGISTRAR'S SIGNATURE Charles Jones	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH	
MABEL		IRENE		FIDDESOP		2a DATE KNOWN OF DEATH		Month 6	Day 24
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		2c DATE PRONOUNCED DEAD	
Female		White		Dec. 23, 1895		72 YRS		Month 6	
7a BIRTHPLACE (State or foreign)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2d HOUR	
Washington D. C.		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George		6:23 M	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during last of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Riverdale		Leland Memorial		Housewife		Own Home			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		P. G.		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4800 Riverdale Road	
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
Edwin		Jett		Mabel		I.		Chase	
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		6003 Res 39th Place		Hyattsville, Md.	
no				Harry Fiddesop Sr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage</u>									15 min
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last									
(b) <u>Bronchogenic Carcinoma</u>									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH		19 P. M.							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John Kehoe		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		John Kehoe, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		June 25, 1968	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		6/27/68		Ft. Lincoln		Colmar Manor P. G. Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons				Hyattsville, Maryland		JUL - 2 1968		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

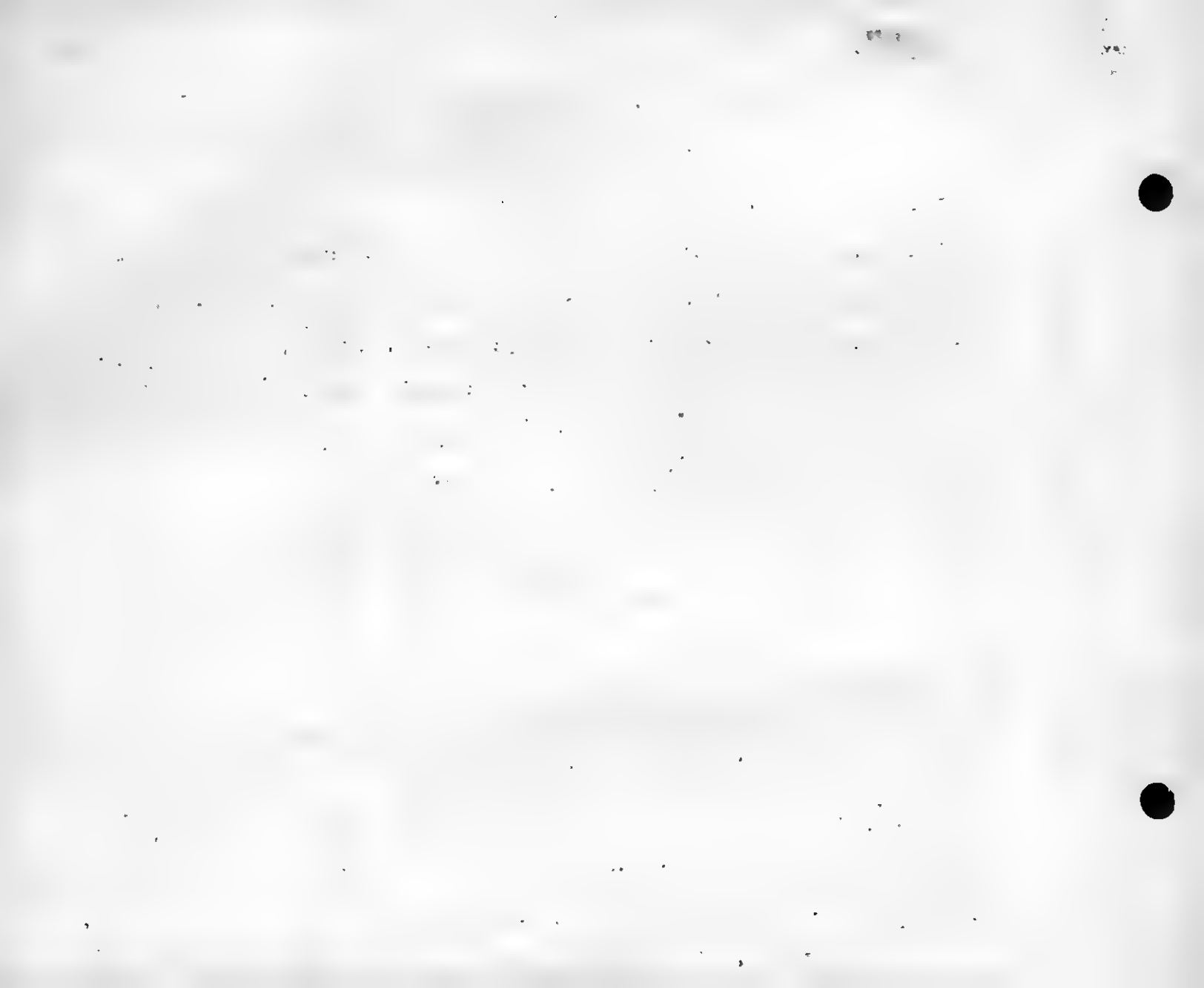
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Zettie			Fields			June 10, 1968		6:40 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		Caucasian		June 13, 1902		65 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Kentucky		U. S. A.		SEP. Prince George's					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Geo. Gen'l Hospital			housewife		Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Apt 204		
Maryland			Prince George's Hillside		YES <input type="checkbox"/> NO <input type="checkbox"/>		5272 Marlboro Pike		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Harvey			Sullivan			Angeline Justice			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes, no, or unknown			403 03 2434 B		Joyce O'Neal		same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute purulent tracheobronchitis with bilateral</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>bronchopneumonia.</u>									
(b) <u>Chronic congestive heart failure.</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiomegaly with marked right ventricular hypertrophy</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (Cor pulmonale).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (this hospital) attended the deceased from May 23, 1968, to June 10, 1968, that (we) lost saw the deceased alive on June 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did) (do) view the body after death.									
22b. SIGNATURE <u>Tomas J. Hernandez</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED June 11, 1968		
22d. PHYSICIAN'S NAME (Type) Tomas J. Hernandez, M. D.					22e. ADDRESS Prince George's General Hospital, Cheverly				
23a. BURIAL, CREMATION, (City)		23b. DATE 6/15/68		23c. NAME OF CEMETERY OR CREMATORY Mt. View Memorial Gardens		23d. LOCATION (City or Town) (County) (State)		Calburn Kentucky Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons 4739 Baltimore Ave. Hyattsville Maryland					25a. REC'D BY REGISTRAR JUN 14 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.


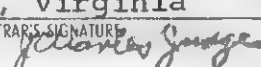
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Charles G. Fisher			2a. DATE OF DEATH Month 6 Day 29 Year 68		2b. HOUR 7:10 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH 1/21/82		6 AGE (In years last birthday) 86 YRS.	IF UNDER YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Internal revenue clerk	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1115 Beall Place
14. FATHER'S NAME First Middle Last not available JOHN FISHER		15. MOTHER'S MAIDEN NAME First Middle Last not available FRANCES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT MEKCADES FLOYD LAUREL MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Quinacril Carcinomatosis</u> 188X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April 1968 to June 29, 1968, that (I) (we) last saw the deceased alive on June 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert P. Wingfield		22c. DATE SIGNED July 1, 1968		22d. PHYSICIAN'S NAME (Type) Robert P. Wingfield	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-2-68		23c. NAME OF CEMETERY OR CREMATORY Redeemer's Baltimore Md	
24. FUNERAL DIRECTOR W. W. Sanderson		25a. REC'D BY REG STRAR JUL - 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last WILL A FLEMING			2a. DATE OF DEATH Month Day Year JUNE 4 1968			2b. HOUR 0303A M			
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 7 Jan 1924		6. AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pittsburg, Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Military			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. CITY OR TOWN Prince G. Hillside		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1402 49th Ave			
14. FATHER'S NAME First Middle Last unknown			15. MOTHER'S MAIDEN NAME First Middle Last unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 465-24-3506		17. INFORMANT Address Roberta Duckett, 1402, 49th Ave Hillside, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 HBP									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly med cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 29 Dec , 19 66 , to 4 Jun , 19 68 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 26 May , 19 68 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE 		DEGREE ROBERT S. NELSON CAPT, USAF, MC		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4 JUNE 1968			
22d. PHYSICIAN'S NAME (Type) ROBERT S. NELSON CAPT, USAF, MC		22e. ADDRESS Malcolm Grow USAF H sp Andrews AFB, Wash, D.C. 20331							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/10/68		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd.,				25a. REC'D BY REGISTRAR DATE E. JUN 10 1968		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) John			First W.		Middle FLETCHER		2a. DATE OF DEATH Month 6 Day 11 Year 68		2b. HOUR 9 1/2 M		
3 SEX male		4. RACE negro		5. DATE OF BIRTH 12/25/83			6 AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	
7a BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. George Md.					
10. CITY OR TOWN OF DEATH Forestville, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Regent			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Fairmont		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Fairmont		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 60262nd Street			
14 FATHER'S NAME James			First Fletcher		15. MOTHER'S M.A.DEN NAME Nellie		First ?		Middle Lost 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (name and rank) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 			17. INFORMANT Mabel Hamilton		Address 10100 Fargo Rd. Landover, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 1967 1967 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1967	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRARY TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cystitis											
19a. DATE OF OPERATION 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cystitis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from June 4, 1968 , to June 11, 1968 , that (I) (we) last saw the deceased alive on June 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W.B. Sheer M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 11, 1968	
22d. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22e. ADDRESS 6900 Marlboro Pike S.E. Wash. D.C.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-14-68		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet		23d. LOCATION (City or Town) Washington		(County) DC		(State)	
24. FUNERAL DIRECTOR H.S. Washington & Sons				ADDRESS 4935 Penna Ave		25a. REC'D BY REGISTRAR JUN 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) James Arthur Furman			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 22 Year 1968			2b HOUR 4:00 AM <input checked="" type="checkbox"/> PM	
3 SEX M	4 RACE W	5 DATE OF BIRTH 15 July 1930	6 AGE (In years last birthday) 37 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0	8 UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 6 Day 22 Year 1968	
7a BIRTHPLACE (State or foreign country) N.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Fireman		12b KIND OF BUSINESS OR INDUSTRY DC Gov't	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b COUNTY Prince George		13c CITY OR TOWN Marlow Heights		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14 FATHER'S NAME Arthur J. Furman		15 MOTHER'S MAIDEN NAME Bessie M. King		13e STREET AND NUMBER 6013 28th Ave.,			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) YES		16b SOCIAL SECURITY NO 1931-53		17 INFORMANT (Father) Arthur J. Furman,		ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Skull fracture							
(c) 							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 							
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 4:00 PM 6 22 68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of car involved in collision			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) US Rt 301 1 1/2 miles S of St Rt 301		21f LOCATION Street or R.F.D. No TB		City or Town P.G. County Md.	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6-22-68	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 6-25-68		23c NAME OF CEMETERY OR CREMATORY Washington National Cem.		23d LOCATION (City or Town) Suitland, Maryland (County) (State)	
24 FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. Suitland, Maryland				25a REC'D BY REG STRAR JUN 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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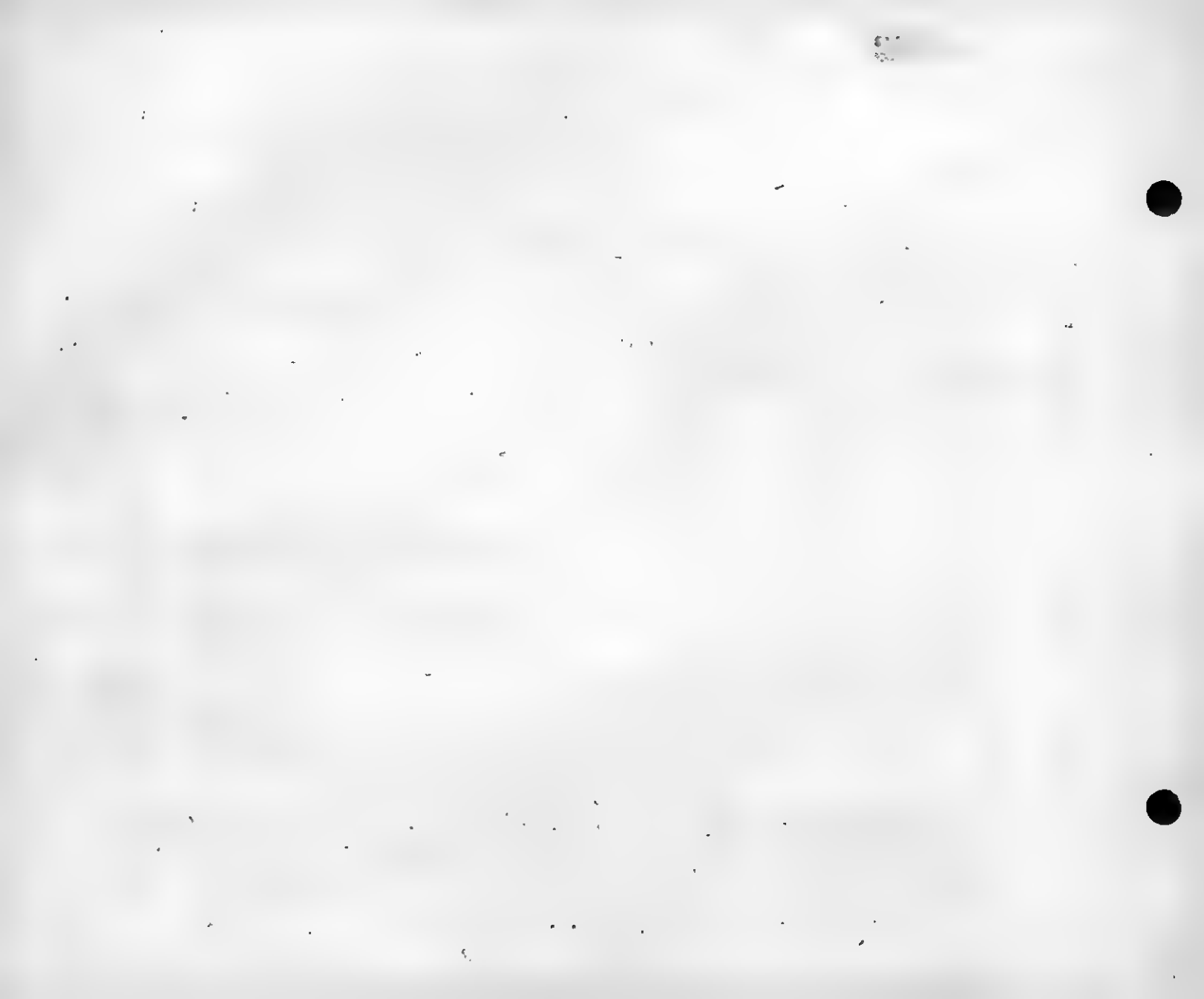
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
Kathleen A. Gaidula						Month Day Year		192:50am M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR MONTHS	8 UNDER 24 HRS DAYS	2c DATE PRONOUNCED DEAD		2d HOUR	
Female	White	3-20-1898	70 YRS			Month Day Year		68 19 3:05am M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
New York		U. S. A.				Prince George's		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital				Housewife		Own Home	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before)		13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13d STREET AND NUMBER			
Pennsylvania		Lackawanna		Taylor		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		514 Union Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Harry C. Phillips			Mamie Unknown			Sheridan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
no			176 22 1984		Peter Gaidula Same as #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure								minutes	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease								over 6 mo.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
John Kehoe		John Kehoe MD Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		6-5-68	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		6/8/68		St. Georges		Taylor Lackawanna Pa			
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.				DATE JUN 7 1968		Charles Judge			

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month			Day	Year	2b. HOUR	
Louisa M. Gardner						6			15	68	6:20	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	White		6/9/70			98 YRS		MONTHS	DAYS	HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Minnesota		US				Prince George's Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale			Leland Memorial			homemaker						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Wash. DC			DC		Wash.			1823 Q Street S.E.				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
John				Zirkelbach		Mary					Shafer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address			
Yes, no, or unknown						Hospital Record						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u> <u>30 years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (the hospital) attended the deceased from <u>JAN. 14, 1952</u> to <u>June 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 14, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Walcott W. Gibson</u>						22c. DATE SIGNED <u>June 15/1968</u>		22d. PHYSICIAN'S NAME (Type) <u>Walcott W. GIBSON, M.D.</u>		22e. ADDRESS <u>4300 5th, Bayside Rd, Marlow Heights, Maryland 20031</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)		
Burial			6/20/1968		National Memorial Park		Fall's Church, Va					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			DATE			
Mittigley			131-11th St. S.E. D.C.			JUN 18 1968			Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) ^{First} Ruth ^{Middle} Amber ^{Last} Gardner					2a. DATE OF DEATH June ^{month} 23 ^{day} Year 68		2b. HOUR M			
3. SEX Female		4. RACE White 1		5. DATE OF BIRTH Jan. 30, 1886		6. AGE (In years lost birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.				
10. CITY OR TOWN OF DEATH University Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7007 Forest Hill Dr			12a. USUAL OCCUPATION (Kind of work done during most of life, if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Ohio			13b. COUNTY ---in		13c. CITY OR TOWN Columbus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 391 Oak St. Apt. B4	
14. FATHER'S NAME ^{First} George ^{Middle} W. ^{Last} Washington					15. MOTHER'S MAIDEN NAME ^{First} Eria ^{Middle} L. ^{Last} Shoemaker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown			16b. SOCIAL SECURITY NO. 290 32 8377		17. INFORMANT Address Dudley Dillard (Same as # 10)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4127 Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Chronic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral Thrombosis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1-11, 1968, to 6-23, 1968, that (I) (we) last saw the deceased alive on 6-23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Arnon Deitz</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6-24-68			
22d. PHYSICIAN'S NAME (Type) <u>ARNON DEITZ, MD</u>					22e. ADDRESS <u>PRINCE GEORGES PLAZA HYATTS MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6/27/68		23c. NAME OF CEMETERY OR CREMATORY Green Lawn		23d. LOCATION (City or Town) (County) (State) Columbus Ohio			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
Francis Gasch's Sons Hyattsville, Md.										
DATE JUL - 2 1968										

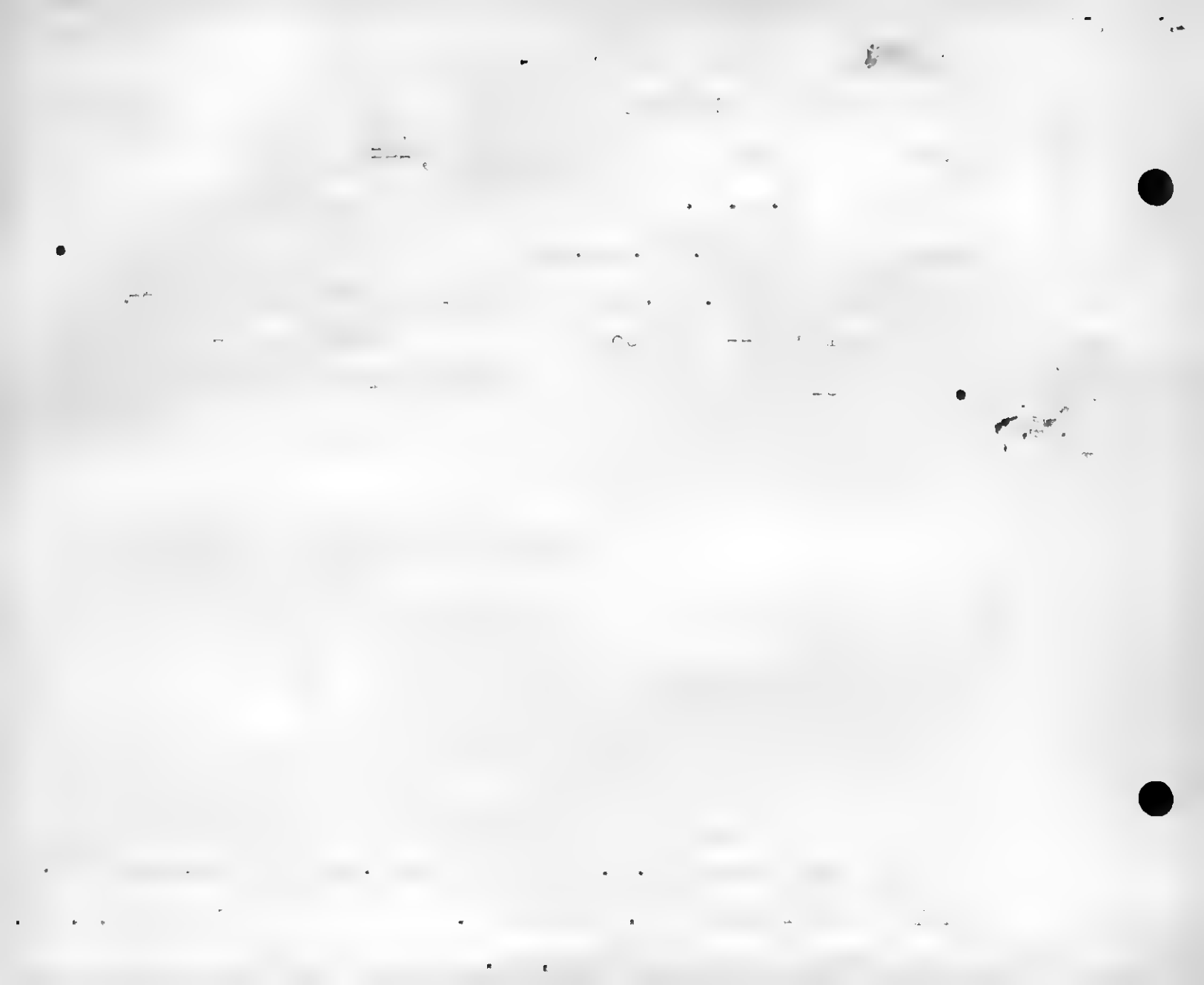


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Mary Elizabeth Garner			2a. DATE OF DEATH Month June Day 13 Year 1968			2b. HOUR 5:45AM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH 11 May, 1899		6 AGE (In years last birthday) 69		7. IF UNDER 1 YEAR MONTHS YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges			
10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Seat Pleasant		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7615 Walker Mill Rd.	
14. FATHER'S NAME First Middle Last Zollar -- Moore			15. MOTHER'S MAIDEN NAME First Middle Last Rose -- Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. --		17 INFORMANT Charles Louis Garner- Same as Item 13-e & 13-c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Site unknown DUE TO, OR AS A CONSEQUENCE OF (c) Site unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/28, 1964 , to 6/13, 1964 , that (I) (we) last saw the deceased alive on 6/12, 1964 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Leon Levitsky, M. D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/14/68			
22d. PHYSICIAN'S NAME (Type) Leon Levitsky, M. D.				22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/15/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cem.		23d. LOCATION (City or Town) (County) (State) Upper Marlboro, P.G., Md.			
24 FUNERAL DIRECTOR Ritchie Brothers Upper Marlboro, Md.				25a. REC'D BY REGISTRAR DATE JUN 19 1968		25b. REGISTRAR'S SIGNATURE W. C. ...			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b HOUR p		
Bob						Gertler		6		22	1968	10:55			
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR p
M	W	9 Mar., 1913		55 YRS						6		22	1968	11:25	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH									
New York		U.S.A.				Prince George									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY									
Cheverly		Prince George		Merchant		LIQUOR									
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		3d INSIDE CITY, MTS?		13e STREET AND NUMBER							
Md.		Prince George Bowie				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13005 Clearfield Drive							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Harry		Gertler						Gussie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WWII				David Greenberg (Brother-in-law)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Laceration of brain													Minutes		
3120 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) Skull Fracture															
DUE TO, OR AS A CONSEQUENCE OF															
(c) Auto accident															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY?					
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b TIME OF INJURY Month, Day, Year HOUR A.M.					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
					10:55 PM 6 22 19 68					Driver of car involved in collision					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f LOCATION Street or R.F.D. No. City or Town County State					
Rt 50 nr Rt 197					Bowie					P.G. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED					
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					6-23-68					
John Kehoe, M.D., Riverdale					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE					23c NAME OF CEMETERY OR CREMATORY					
Burial					6/25/68					Wellwood Cemetery Farmingdale, L.I., N.Y.					
24 FUNERAL DIRECTOR					25a REC'D BY REG STRAR					25b REGISTRAR'S SIGNATURE					
Bernard Dantransky & Sons					3501-14th St. N.W. Washington, D.C.					JUN 26 1968					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Jordan papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR		
WILLIAM CARTER GIBSON						JUNE 23 1968		0410M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		15 May 1892		76 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Georgia		USA				Prince George				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Andrews AFB		Malcolm Grow USAF Hosp				Laborer		Paper		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Virginia			Fairfax		Arlington		YES		3814 North Dickerson	
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost							
WILLIAM GIBSON			LOUISE CARTER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO			434-05-7992		3814 N. Dickerson Mrs James Jernigan, Arlington, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia, probably secondary to										
144 X DUE TO, OR AS A CONSEQUENCE OF pneumonia										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
(b) Squamous cell carcinoma, floor of mouth										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>										
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										
21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (X) (this hospital) attended the deceased from 15 June, 1968, to 23 June, 1968, that (X) (we) last saw the deceased alive on 23 June 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John D. Halliwell Maj USAF MC DEGREE										
22c. DATE SIGNED 23 June 68										
22d. PHYSICIAN'S NAME (Type) TOLLIE B COLE, CAPT USAF MC										
22e. ADDRESS MALCOLM GROW USAF HOSP, MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify)										
23b. DATE 6-27-68										
23c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH CEM										
23d. LOCATION (City or Town) (County) (State) BASTROP LOUISIANA										
24. FUNERAL DIRECTOR W W CHAMBERS ADDRESS 1400 CHAPIN ST. N.W. DC.										
25a. REC'D BY REGISTRAR DATE JUN 25 1968										
25b. REGISTRAR'S SIGNATURE Charles Judge										

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH				2b HOUR			
John						Glasco		<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 6-20-68 19 10:12am				12am			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD				2d HOUR		
Male	Negro	4-15-1869		99 YRS	MONTHS DAYS		HOURS MIN		Month 6 Day 20 Year 68 19 11:15am				15am		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH									
Maryland		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's		Md.							
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince George Hospital													
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before address only) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER							
Maryland		Prince George's		Brandywine		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. 3, North Keys Road							
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last	
Unknown								Onn Bond							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS									
No				Beatrice Pinkney		Rt. 3 - Box 345 - H.									
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:												minutes			
IMMEDIATE CAUSE (a) Heart failure												unknown			
DUE TO, OR AS A CONSEQUENCE OF arteriosclerotic heart disease															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
42															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
		HOUR A.M. P.M. 19													
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No				City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		John Kehoe		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED		6-21-68	
EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale, Md.		ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)									
Burial		June 24, 1968		John Keeley Ch. Cem.		Aguasco - P. G. Co's Md.									
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE									
Martell Adams		Aguasco, Md.		DATE JUN 26 1968		Charles Judge									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Wilbur W. Goolsby Sr.			2a. DATE OF DEATH Month 6 Day 22 Year 68			2b. HOUR 1:20											
3. SEX Male		4 RACE White		5. DATE OF BIRTH 10/22/07		6 AGE (in years lost birthday) 60 YRS.		7 UNDER 1 YEAR MONTHS 0		8 UNDER 24 HRS. DAYS 0		9 UNDER 24 HRS. HOURS 0		10 UNDER 24 HRS. MIN. 0			
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Prince George's Md.								
10 CITY OR TOWN OF DEATH Riverdale			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) baker			12b. KIND OF BUSINESS OR INDUSTRY food store								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Riverdale			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 5306 Riverdale Rd.					
14. FATHER'S NAME First John Middle Robert Last Goolsby			15 MOTHER'S MAIDEN NAME First Laura Middle Bell Last Proffitt														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 229 18 3071			17. INFORMANT Address Aurelia M. Goolsby Same as #13 (wife)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Concomitosis 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adeno-carcinoma of Rectum DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1541																	
19a. DATE OF OPERATION 2-15-68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Localized Melanosis, umbilical			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Dec 1967 , to June 22, 1968 , that (I) (we) last saw the deceased alive on 6-22-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE D. R. Purdie M.D.			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 6-22-68								
22d. PHYSICIAN'S NAME (Type) D. R. Purdie, M. D.			22e. ADDRESS Riverdale, Maryland														
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 6/25/68			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.								
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR JUN 27 1968			25b. REGISTRAR'S SIGNATURE Charles Judge											



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Agnes M. Cordina</i>			2a. DATE OF DEATH Month <i>6</i> Day <i>19</i> Year <i>68</i>			2b. HOUR <i>7:30</i> M					
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>4-15-1920</i>		6. AGE (In years lost birthday) <i>48</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Penna</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George</i> Md.					
10. CITY OR TOWN OF DEATH <i>Forestville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Regent</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE <i>Md.</i>			13b. COUNTY <i>PG</i>		13c. CITY OR TOWN <i>Marlow Heights</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2506 Olson Street</i>		
14. FATHER'S NAME First <i>Stephen</i> Middle <i>Malinak</i> Last <i>Malinak</i>			15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT (Husband) <i>George J. Gordian,</i>			Address <i>Same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cerebral embolism</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral embolism, old + multiple</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic heart disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>41X Urethral</i>											
19a. DATE OF OPERATION <i>4-1-68</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Urethral</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 10, 1966</i> , to <i>June 14, 1968</i> , that (I) (we) last saw the deceased alive on <i>June 14, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>A. B. Steen - MD</i>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>June 19, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Agnes M. Cordina</i>			22e. ADDRESS <i>1000 W. 11th St. Baltimore, Md.</i>								
23a. BURIAL, CREMATION, REBURY (Specify)			23b. DATE <i>6-22-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Washington National Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>			
24. FUNERAL DIRECTOR <i>Wilhelm Funeral Home</i> 4308 Suitland Rd. SE, Suitland, Maryland						25a. REC'D BY REGISTRAR <i>JUN 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



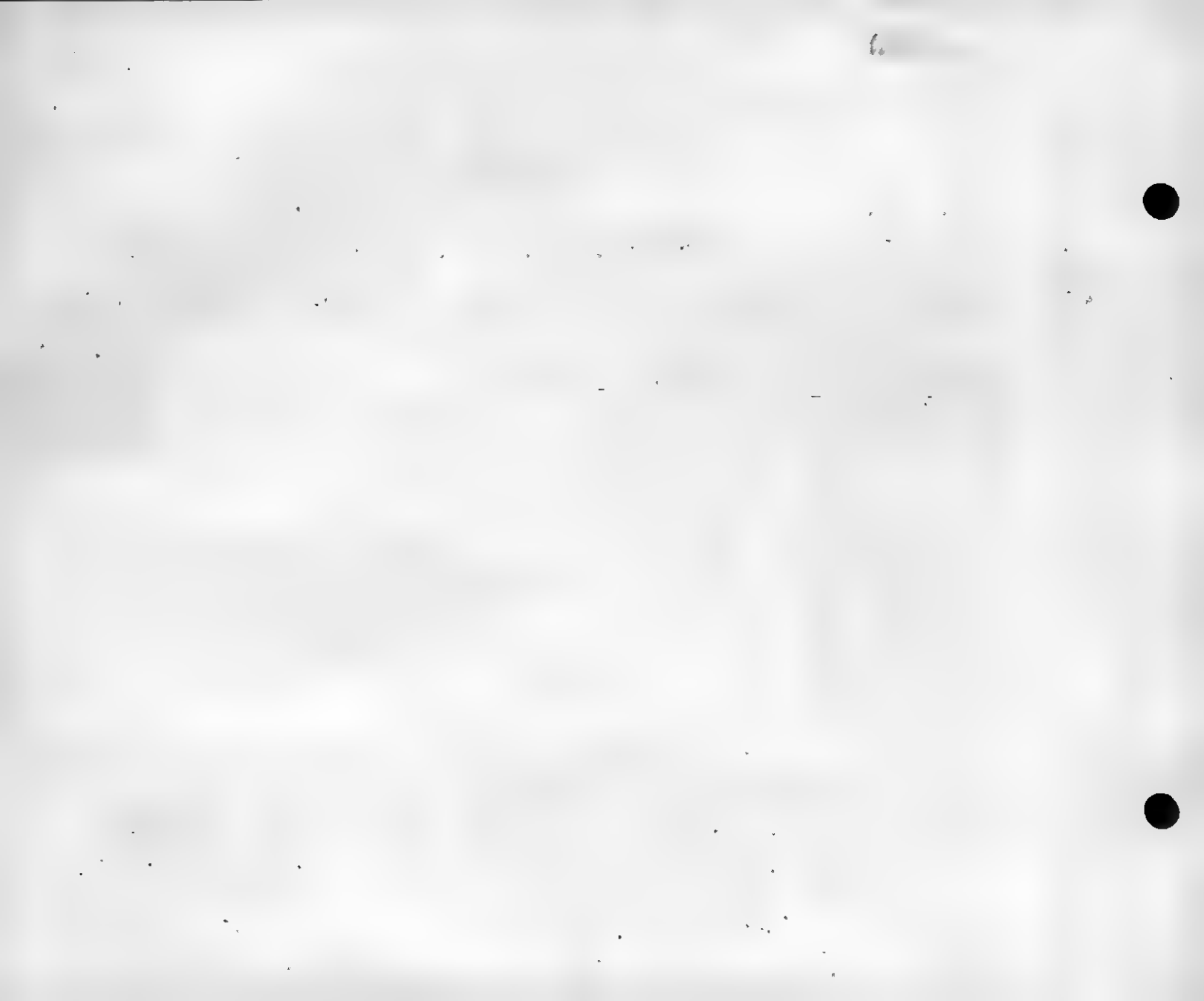
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

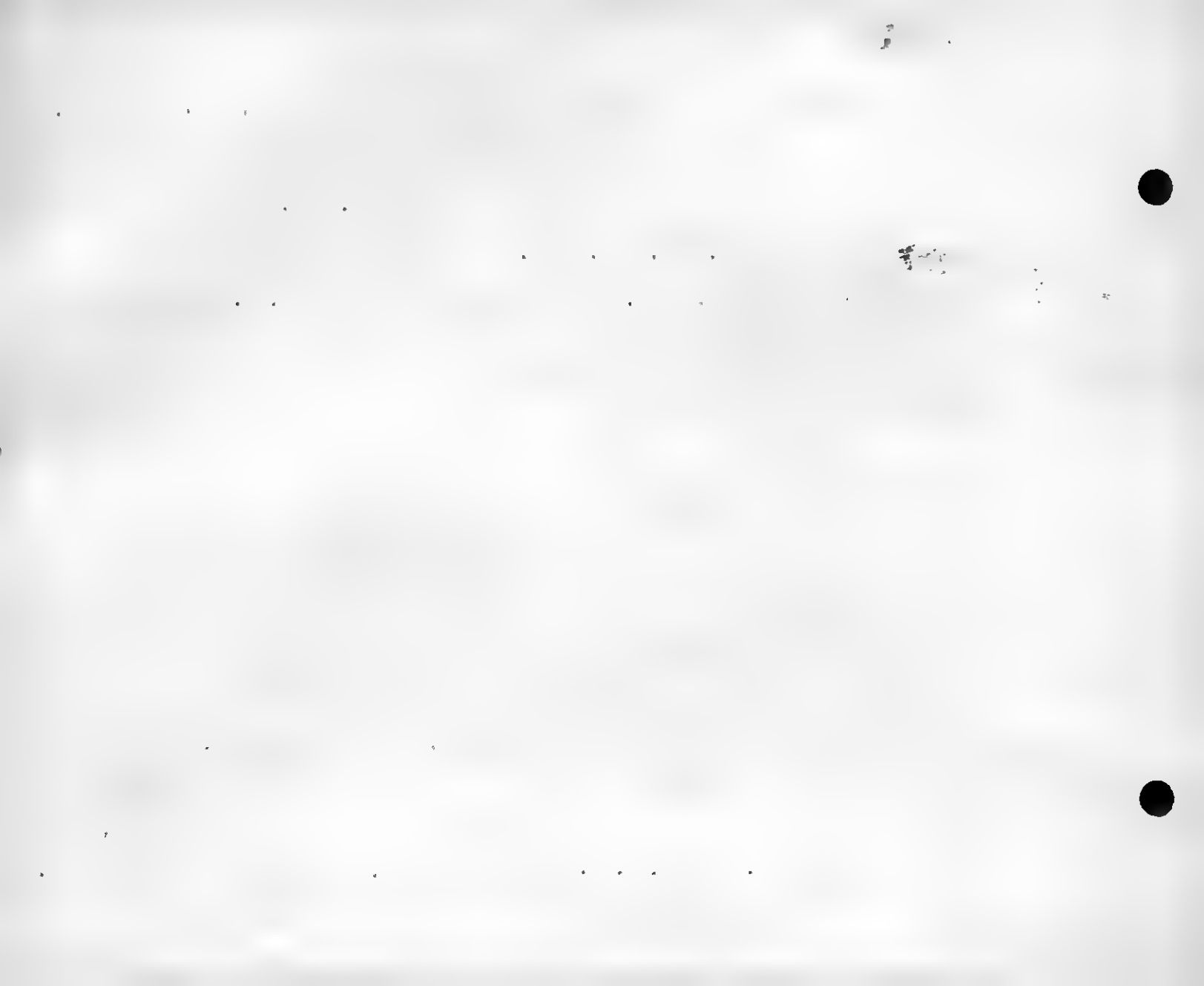
1. DECEASED NAME (Type or print) First Middle Last Herbert H. Grady			2a. DATE OF DEATH Month Day Year June 15 1968			2b. HOUR a.m. or p.m. 5:30 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 14, 1913		6. AGE (In years last birthday) 55 YRS	
7a. BIRTHPLACE (State or foreign country) N. Car.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Male nurse		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 5107 Queens Chapel Rd.		14. FATHER'S NAME First Middle Last Daniel Grady		15. MOTHER'S MAIDEN NAME First Middle Last Margaret Harris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 241-30-4019		17. INFORMANT Address Agnes M. Grady (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCC/USION</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4201</u> (b) <u>HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Atherosclerosis - Osteoporosis -</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 4, 1968</u> , to <u>June 15, 1968</u> , that (I) (we) lost the deceased alive on <u>June 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Chas. V. Pate MD</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/14/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>CHAS. V. PATE MD</u>		22e. ADDRESS <u>335 W. 5TH ST. WASH. DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6/18/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash., D.C.</u>	
24. FUNERAL DIRECTOR <u>Valley's Funeral Home, Inc.</u>				ADDRESS <u>Mt. Rainier Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 20 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR
Maggie			E		Gray	June 13 1968			6.00 AM
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		Negro		23 July 1890			77 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Pr. Geo.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Pr. Geo. Gen. Hosp.						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Pr. Geo.		Brandywine		Rt. 1. Box 20 C		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
James A.				Hawkins		Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT				
					William S. Gray 8118 Central Ave. Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident - Prob. hemorrhage</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>C</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443x <u>Congestive Heart Failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that he (this hospital) attended the deceased from <u>June 12, 1968</u> , to <u>June 13, 1968</u> , that we (we) lost saw the deceased alive on <u>June 13, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) not view the body after death									
22b. SIGNATURE <u>Edwing Jensen</u>					22c. DATE SIGNED June 13, 1968				
22d. PHYSICIAN'S NAME (Type) Edwing J. Jensen, M. D.					22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 15, 1968		Gibbons Ch. Cemetery Brandywine P. Geo. Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REGD BY REG. STRAR		25b. REGISTRAR'S SIGNATURE			
Master Adams		Aquasco, Md.		JUN 18 1968		Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH Month Day Year			2b. HOUR		
Roland Eugene Gray Gray						6 23 68			11:30 a.m.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR		
M	W	25 Sept 1926	41 YRS			6 23 68			11:5 a.m.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Prince George's Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last year, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hosp			Employed Plasterers Laborer Business			Construct		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Prince George			Mitchellville			10 Cambridge Court		
4 FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last		
Jesse F. Gray						Grace Pumphrey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
Yes			W.W.II			678-24-8951 Dolores M. Gray Mitchellville, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest									Minutes		
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
27											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 11:30am 6 23 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot self in back yard of home.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No City or Town County State 10 Cambridge Court P.G. (Mitchellville) Md. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				John Kehoe, M.D., Riverdale				22b. DATE SIGNED 6-23-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				June 26, 1968				Epiphany Cemetery			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR			
Ritchie Bros. Upper Marlboro, Md.								DATE JUN 26 1968			
								25b. REGISTRAR'S SIGNATURE Charles J. J...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #23c, Film #401 6/25/68 km									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR A	
Florence			Griffith			June 17, 1968		11:15 M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negro		June 19, 1902		65 YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Prince George's			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Geo. General Hosp.						
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Prince George's			Upper Marlboro		Route #3	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Samuel Crowdy			Julia Gross						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
						Horace Crowdy-brother-			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure - Congestive</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sudden cardiac arrest in the hospital</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probably coronary arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Severe anemia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from <u>June 16, 1968</u> to <u>June 17, 1968</u> , that (2) (we) last saw the deceased alive on <u>June 17, 1968</u> and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Edwin Jensen, M.D.</u>					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>June 18, 1968</u>
22d. PHYSICIAN'S NAME (Type) Dr. Edwin Jensen					22e. ADDRESS Prince Geo. General Hosp., Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/21/68		Union Wesley Methodist Church		Upper Marlboro, Md.			
24. FUNERAL DIRECTOR <u>John T. Stewart</u>					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE Md.		
Stewart Funeral Home-4001 Benning Rd.					E. JUN 21 1968		<u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #2a Film #G402 7/26/68 vmp											
1 DECEASED-NAME (Type or print) Annie Julia Grigsby						2a DATE OF DEATH Month June Day 1 Year 68			2b HOUR 7,30AM		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 19 Dec., 1894		6 AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges			Md		
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.,		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Maid		12b KIND OF BUSINESS OR INDUSTRY University of Maryland					
13a USUAL RESIDENCE (Where deceased resided, if institution residence before admission) STATE Maryland		13b CITY Pr. Geo. Riverdale		13c CITY OR TOWN Riverdale		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5416 56th Ave., APT. 302			
14. FATHER'S NAME First Middle Last Minor Sullivan				15. MOTHER'S MAIDEN NAME First Middle Last Unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b SOCIAL SECURITY NO. 229 05 4405A		17 INFORMANT William P. Grigsby		3715 Shepard Street Brentwood, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure with atrial fibrillation.											
DUE TO, OR AS A CONSEQUENCE OF (b) Splenic Infarctions.											
DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of the liver with marked fatty metamorphosis.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertensive cardiovascular disease.											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cal. examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a I certify that (I) did not attended the deceased from May 29, 1968 , to June 1, 1968 , that (I) was last saw the deceased alive on June 1, 1968 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death											
22b SIGNATURE Albert Roth				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6-2-68					
22d PHYSICIAN'S NAME (Type) Albert Roth, M. D.				22e. ADDRESS 5409 Riverdale Rd., Riverdale, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 6/5/68		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.					
24. FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS Hyattsville, Md.		25a REC'D BY REGISTRAR JUN 10 1968		25b REGISTRAR'S SIGNATURE James Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR				
Edgar E			Grist Jr.			DATE ESTIMATED <input checked="" type="checkbox"/> 6-9-68		1968 12:31a				
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR				
Male	White	8-12-1935	32 YRS	MONTHS	DAYS	6 Month 9 Day 68		1:20am				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Washington		USA				Prince George's Md						
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY				
Cheverly			Prince George's Hospital									
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland			Prince George		Adelphi		YES <input type="checkbox"/> NO <input type="checkbox"/>		7911 Riggs Road			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
Edgar E. Grist Jr.			Myrtal Frances White									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT						
						Mrs. Edgar E. Grist Jr. 111 - Riggs Rd Adelphi						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Laceration of brain												
DUE TO, OR AS A CONSEQUENCE OF Trauma - auto accident												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
2a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			12:30am 6-9- 1968		Driver of car involved in collision							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State			
		St. Rt. 381 Brandywine					Prince George County, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type)			John Kehoe MD			Riversdale, Md.		22b. DATE SIGNED		6-10-68		
23a BURIAL (CREMATION, REMOVAL) (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town)		(County)		(State)	
			June 11-1968		St. Luke's		Baltimore, Md.					
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REG STRAP'S SIGNATURE				
Arthur Walters			254 Carroll St.			DATE JUN 11 1968		Charles Judge				

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, and any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		ESTI MATED <input checked="" type="checkbox"/> 6-9-68		Month Day Year		2b. HOUR	
Edgar		E		Grist		111		12		31		am			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (n years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month Day Year		2d. HOUR		
Male	White	8-23-1955		12 YRS	MONTHS DAYS		HOURS MIN		6		9		68 19 1:20 am		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								Md	
Princeton, New Jersey						Prince George's									
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY									
Cheverly		Prince George Hospital													
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before address only) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
Maryland		Prince George's		Adelphi		YES <input type="checkbox"/> NO <input type="checkbox"/>		7911 Riggs Road							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Edgar E.								Grist J. Thomas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		7911 Riggs Rd							
				Mr. Edgar E. Grist Jr.		Adelphi, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Laceration of brain</u>															
DUE TO, OR AS A CONSEQUENCE OF <u>Trauma - auto accident</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) _____															
DUE TO, OR AS A CONSEQUENCE OF _____															
(c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
MEDICAL CERTIFICATION															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				12:30 am 6-9-1968				Passenger in car involved in collision.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
				St. Rt. 381, Brandywine				Prince George County, Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)				6-10-68			
John Kehoe MD				Riverdale, Md.											
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or town) (County) (State)			
Burial				June 11-68				St. Luke's				P. R. R. Md.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John W. Tatters				254 Laurel St. N.W.				DATE JUN 11 1968				Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A. M. P. M.
Edward			A		Hall	6 8 1968			4:00 A.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		8/22/1907		60 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.				Prince Georges Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Glenn Dale			Glenn Dale Hospital			Painter		Unknown	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
D.C.						Washington, D.C.		829 H St. S.E.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
Edward			L		Hall	Annie Phillips			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
Yes			WW 2		Decedent				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4130 DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent cerebrovascular accident with focal encephalomalacia DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive and arteriosclerotic cardiovascular disease 4130									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic alcoholism.									years
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/11, 1967, to 6/8, 1968, that (X) (we) lost saw the deceased alive on 6/8, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Moe Weiss						22c. DATE SIGNED 6/8/68			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.						22e. ADDRESS Glenn Dale Hospital, Glenn Dale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
CREMATION			6-10-68		CEDAR HILL		SUTLAND P.G.C. MD		
24. FUNERAL DIRECTOR LIVES FUNERAL Home						25a. REC'D BY REGISTRAR DATE JUN 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print) <u>William Keller Hartman</u>						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 6-2-68 19:35 pm		2b. HOUR	
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>8 June 1924</u>	6. AGE (in years last birthday) <u>43</u> YRS.	7. UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	8. IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u>	2c. DATE PRONOUNCED DEAD Month <u>6</u> Day <u>2</u> Year <u>1968</u>		2d. HOUR <u>1:15 pm</u>	
7a. BIRTHPLACE (State or foreign country) <u>Ohio</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George's</u> Md.			
10. CITY OR TOWN OF DEATH <u>Cheverly</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince George Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life) <u>Asst. Mgr. Ins. Co.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Prince George</u>		13c. CITY OR TOWN <u>Bowie</u>	13d. INSIDE CITY, Y.N. IS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>4800 Riverton Lane</u>		
14. FATHER'S NAME First <u>Benjamin</u> Middle <u>W.</u> Last <u>Hartman</u>			15. MOTHER'S MAIDEN NAME First <u>Edna</u> Middle <u>Ricker</u> Last <u> </u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <u>209-12-2489</u>			17. INFORMANT <u>Mrs. Barbara J. Hartman</u>			ADDRESS <u>4800 Riverton Lane Bowie, Md.</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF <u> </u> (c) <u> </u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200</u>									
19a. DATE OF OPERATION <u> </u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u> </u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. <u> </u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>		22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		EXAMINER'S NAME (Type) <u>John Kehoe MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <u>Riverdale, Md.</u>		22b. DATE SIGNED <u>6-3-68</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 6, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Rosemont Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bloomsburg Penna.</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc., 8434 Ga. Ave. S.S. Md.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey</u>		25c. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Minnie Estell Hayes			2a. DATE OF DEATH Month Day Year June 6, 1968			2b. HOUR 11:40 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2/22/94		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired clerk U.S. Dept of		12b. KIND OF BUSINESS OR INDUSTRY Ag.			
13a. USUAL RESIDENCE (Where deceased lived, if institution) Res. dence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3450 1/2 Ledo Terr.	
14. FATHER'S NAME First Middle Last Henry Dameron			15. MOTHER'S MAIDEN NAME First Middle Last Cora Crabbe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of serv. ca.) unknown			16b. SOCIAL SECURITY NO. U			17. INFORMANT Julia Myers 7105 Bridal Path Lane Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Multiple C.V.A.s and embolism DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 7		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1967 , to 6 June, 1968 , that (I) (we) last saw the deceased alive on 6 June, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Aaron Deitz					22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) Aaron Deitz		
22e. ADDRESS Hyattsville, Md.									
23a. B. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 6/10/68		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges County, Md.			
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.					25a. REC'D BY REG. STRAR DATE JUN 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND		c. LENGTH OF STAY IN 1b TEMPLE HILLS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUITLAND NURSING HOME		d. STREET ADDRESS 6448 PORTAL AVENUE	
3. NAME OF DECEASED (Type or print) LOTTIE V. HEDRICK		4. DATE OF DEATH Month JUNE Day 23 Year 19 68	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1893
9a. AGE (In years last birthday) 74 yrs		9b. IF UNDER 1 YEAR Months 10 Days 23 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN GUY		14. MOTHER'S MAIDEN NAME MILDRED BAGGETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. FAYE BRIESMASTER, DAUGHTER, SAME AS # 2	
17. INFORMANT FAYE BRIESMASTER, DAUGHTER, SAME AS # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic DUE TO (b) Hypertension DUE TO (c) Arteriosclerotic Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4411		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1958 to 6-23-1968 , that (I) (we) last saw the deceased alive on 6-23-1968 , and that death occurred at 7:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE John G. Hedrick		22b. DATE SIGNED 6-23-68	
22c. PHYSICIAN'S NAME (Type) John G. Hedrick		22d. ADDRESS 2804 Nichols Ave S.E.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6/26/68	23c. NAME OF CEMETERY OR CREMATORY CATTLETT CEMETERY	23d. LOCATION (City or Town) (County) (State) CATTLETT, VIRGINIA
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR JUN 27 1968 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Carolyn R. Hibbs			2a. DATE OF DEATH June Month 20 Day 1968			2b. HOUR 1:30 P.M.				
3 SEX Female		4. RACE White		5. DATE OF BIRTH July 13 1920		6 AGE (in years lost birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Wash, D.C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Hosp			12a. USUAL OCCUPATION (Kind of work done during most of work life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9310 Calanda Street	
14 FATHER'S NAME First Middle Last George E Gentner			15. MOTHER'S MAIDEN NAME First Middle Last Caroline Rodgers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address James B. Hibbs same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic melanocarcinoma of liver 1968 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Melanocarcinoma of eye DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos. 3 1/2 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 17.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 1 P.M. 6 20 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5-6 , 1968, to 6-20 , 1968, that (I) (we) last saw the deceased alive on 6-14 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Jeanne C. Bateman, M.D., F.A.C.P. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-21-68				
22d. PHYSICIAN'S NAME (Type) Jeanne C. Bateman, M.D.				22e. ADDRESS 312 So Wash. St. Alex., Va.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-22-1968		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem		23d. LOCATION (City or Town) (County) (State) Hyattsville Md				
24. FUNERAL DIRECTOR Valley Funeral Home				ADDRESS Mt. Rainier, Md.		25a. REC'D BY REGISTRAR DATE JUN 24 1968		25b. REGISTRAR'S SIGNATURE J. J. Judge		



FOR STATE HEALTH DEPT

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

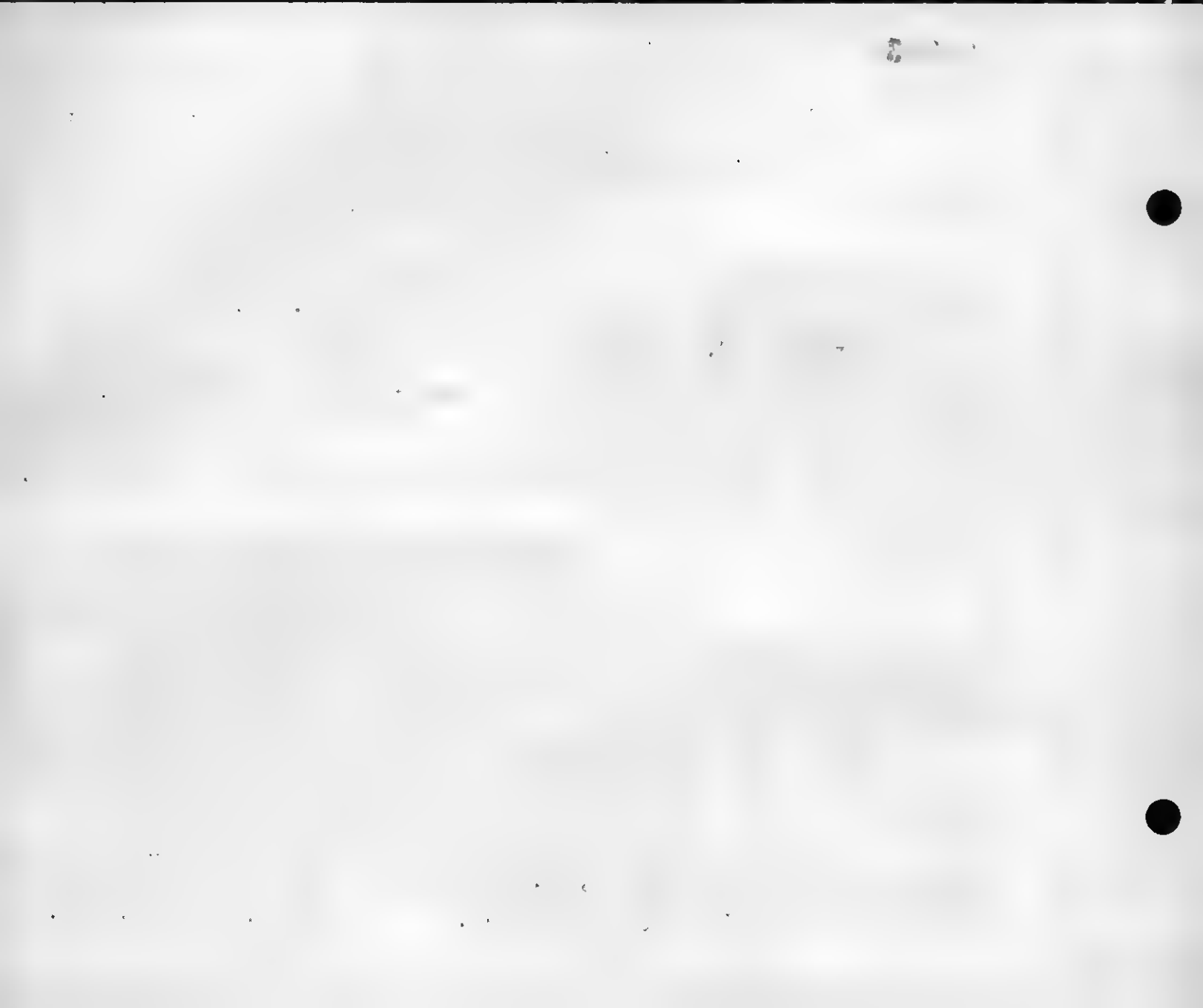
1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 6-16-68 194: 60pm	2b HOUR
Walter			LISTER	Himes Jr.		
3. SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	7-2-1917	50 YRS		6 16 68	10:24pm
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH			
Penna.	USA		Prince George's			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY
Cheverly		Prince George Hospital		Retired Military		Army
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland		Prince George's Bradbury Park			2010 Houston Avenue	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME	
Walter Himes					? Capner	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give year or dates of service)		17 INFORMANT (Wife)		
Yes		1940-1962		Unknown		
				Florence C. Himes, 4818 Eastern Lane.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure						minutes
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease						unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
(b)						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
Diabetes mellitus - over 3 yrs.						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED	
EXAMINER'S NAME (Type)		John Lehoe MD Riverdale, Md.			6-17-68	
23a BURIAL CREMATION, BY WHOM (Specify)		23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		6-20-68	Arlington National		Arlington, Virginia	
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE	
Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. SE, Suitland, Maryland				DATE JUN 21 1968	Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Helen V Holland						Month Day Year		19:10am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
Female	Negro	2-27-1921	47 YRS	MONTHS DAYS		HOURS MIN.		2d. HOUR		
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland						Prince George's		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if not institution)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Calvert Huntingtown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 521, Box 678		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Maurice S. Brooks			Agnes Brooks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
					John Holland		Huntingtown, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Heart failure									over 2 hrs.	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease									over 2 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			6-5-68				
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county)				
Riverdale, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
6-9-68		6-9-68		Plum Pt. Ch. Cem.		Plum Pt..		Cal. Md.		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Larkney E. Sewell - Prince Fred.					Ms.		DATE JUN 10 1968		Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-43, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
James Jackson						MAY 6-7-68		11:20 AM	
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	7 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	Negro		61? YRS			Month 6 Day 7 Year 68		2:15pm M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
						Prince George's Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Tuxedo			Near of 5050 Tuxedo Road						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			13b. CITY OR TOWN		13c. INSIDE CITY, YRS?		13e. STREET AND NUMBER		
Maryland			Prince George		Tuxedo YES <input type="checkbox"/> NO <input type="checkbox"/>		Near of 5050 Tuxedo Rd.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
			229-26-1238		F.B.I. File # 1007548				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4100 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John Kehoe MD				Riversdale, Md.		22b. DATE SIGNED 6-10-68	
EXAMINER'S NAME (Type)		John Kehoe MD				Riversdale, Md.		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-14-68		23c. NAME OF CEMETERY OR CREMATORY V. of Md. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 18 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

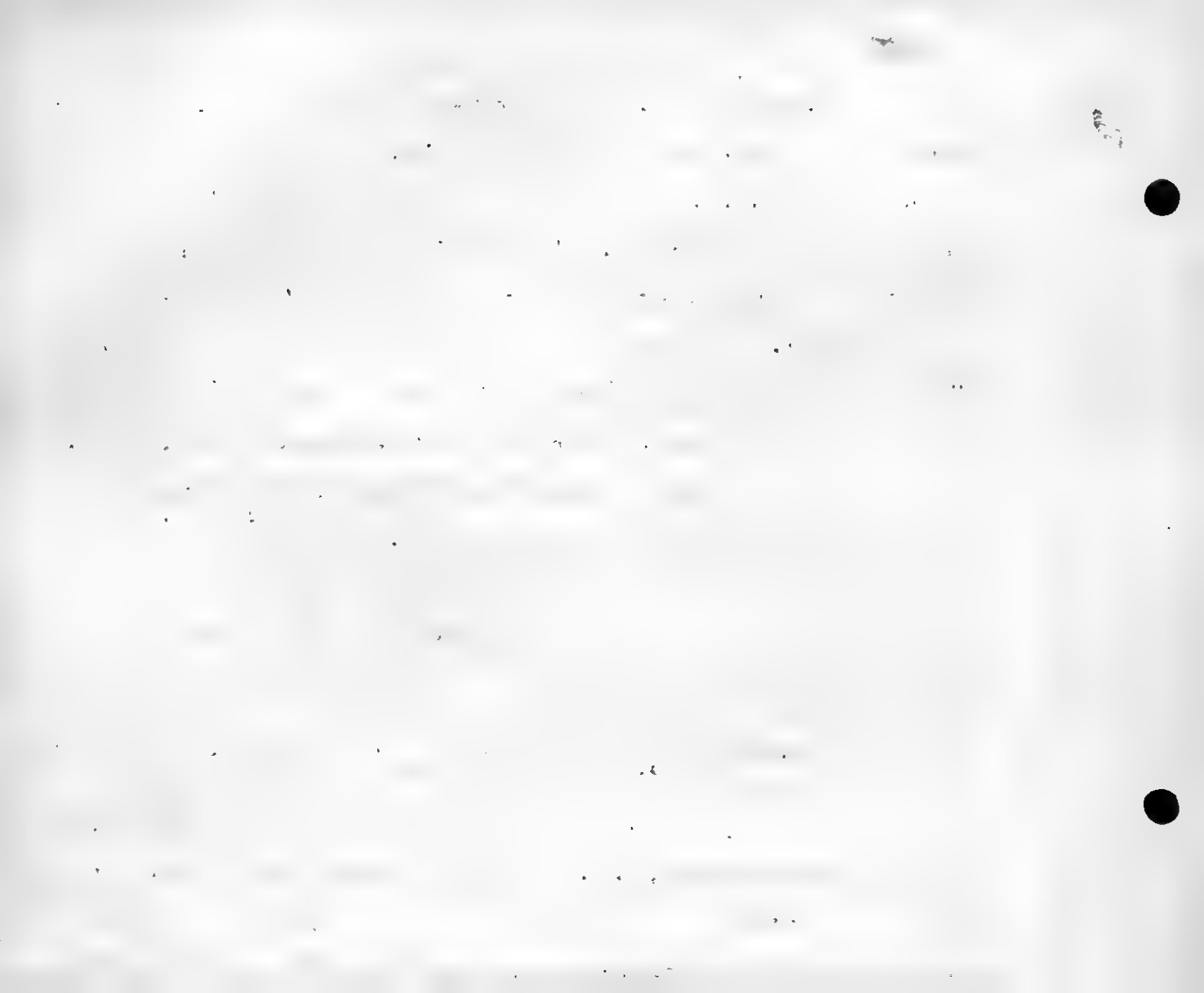
1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF EST DEATH MATED <input checked="" type="checkbox"/> 6 20 1968			2b HOUR p 6:30 M
Henry Natlaniel Johnson									
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD Month 6 Day 20 Year 19 68	2d HOUR p 6:30 M
Male	W	May 30 1954	14 YRS						
7a BIRTHPLACE (State or foreign country) A., I.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md			
10 CITY OR TOWN OF DEATH Riverdale		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beland Memorial Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) STATE Md.		13b COUNTY Anne Arundel		13c CITY OR TOWN Glen Burnie		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 611 Hollins Ferry Rd.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
James C. Johnson Sr			Edith Johnson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give year or dates of service)		17 INFORMANT		ADDRESS			
No		No		Edith Johnson		Same			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 816.1 Laceration of brain DUE TO, OR AS A CONSEQUENCE OF Skull fracture Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 220									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. 5:30 P.M. 6 20 68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Passenger in truck which overturned				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) street		21f LOCATION Street or R.F.D. No. City or Town County State Bond Mill Rd. Laurel P.G. Md.					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED 6-21-68			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		6-25-68		Mt. Auburn Cem.		Baltimore Md.			
24 FUNERAL DIRECTOR Henry O. Wilson 1000 Brantley Ave.				ADDRESS		25a REC'D BY REGISTRAR DATE JUN 27 1968		25b REGISTRAR'S SIGNATURE John Judge	

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Reathie M. Johnston			2a. DATE OF DEATH Month June Day 25 Year 1968		2b. HOUR 9:05 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH 11/4/1892		6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Prince George's	13c. CITY OR TOWN Lanham	3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7400 Lois Lane
14. FATHER'S NAME First Middle Last Charles T. Riley			15. MOTHER'S MAIDEN NAME First Middle Last Clara Blubaugh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 223 50 5041		17. INFORMANT Address Irene Francis Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure with bilateral pulmonary edema, marked. DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis, marked, with myocardial fibrosis. DUE TO, OR AS A CONSEQUENCE OF (c) Bronchial Asthma (Clinical). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from June 7, 1968 , to June 25, 1968 , that (I) (we) last saw the deceased alive on June 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (saw) view the body after death.					
22b. SIGNATURE <i>Tomas Hernandez</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 25, 1968	
22d. PHYSICIAN'S NAME (Type) Tomas Hernandez, M. D.		22e. ADDRESS Prince George's General Hospital, Cheverly			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/28/68	23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City or Town) (County) Waynsboro Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR JUL - 2 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

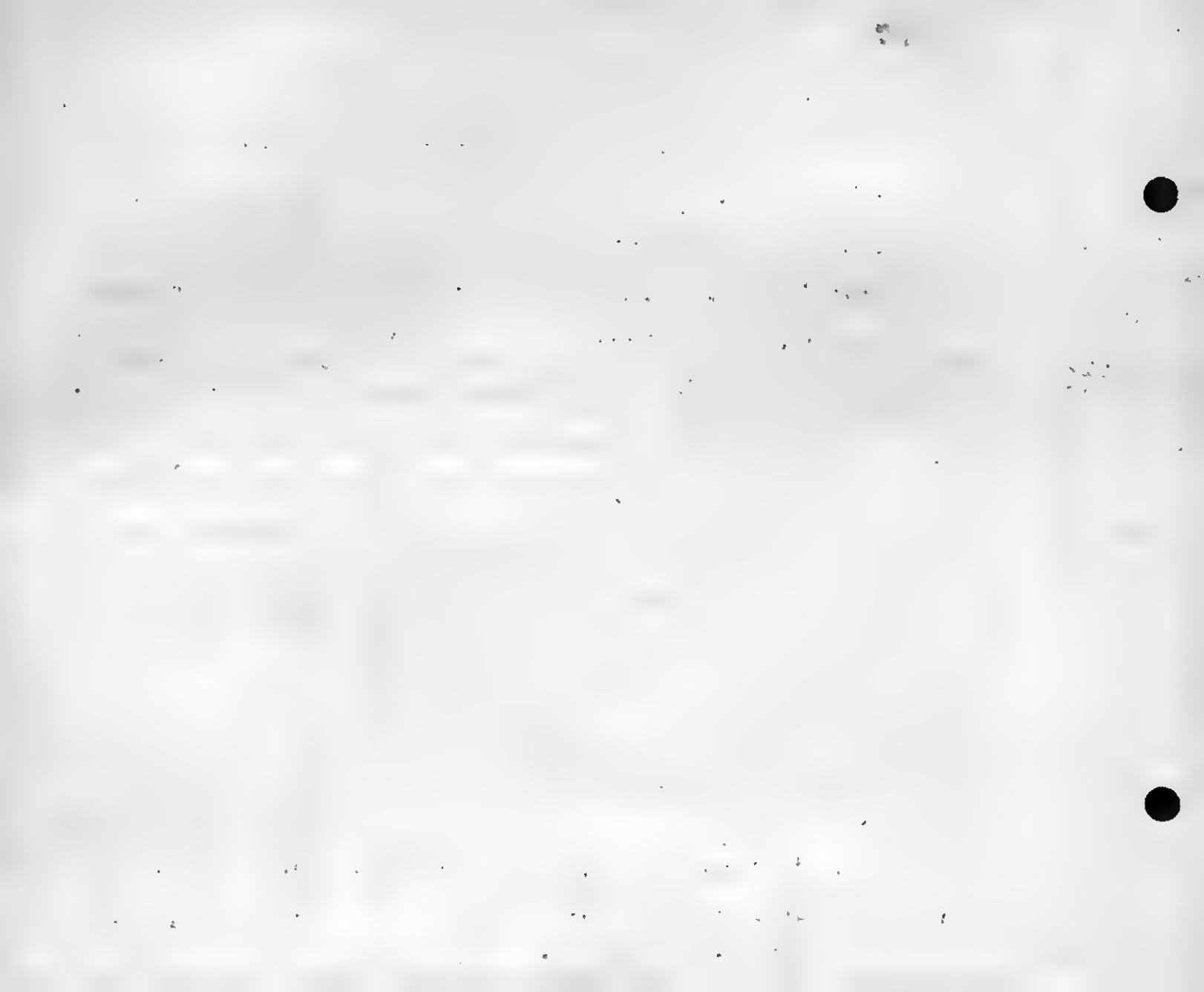
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First Nellie		Middle M.		Last Jones		2a. DATE OF DEATH June Month 11 Day 1968			2b. HOUR 5:55AM
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-22-1915			6. AGE (In years last birthday) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1812 64th Avenue				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. CITY P.G.		13c. CITY OR TOWN Cheverly		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1812 64th Avenue			
14. FATHER'S NAME First Middle Last William Harris				15. MOTHER'S MAIDEN NAME First Middle Last Martha J Childress							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) No		16b. SOCIAL SECURITY NO. 224 14 7589		17. INFORMANT 6005 88th Place Robert Jones New Carrollton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombo-embolic heart disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>long standing kidney disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(one kidney removed)</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <u>unknown</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1951</u> , 19 <u> </u> , to <u>1968</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>June 6</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Philip Bloemsma</u>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-11-68							
22d. PHYSICIAN'S NAME (Type) Philip Bloemsma M.D.		22e. ADDRESS 7701 Conn. Ave. Chevy Chase, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-14-1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.					
24. FUNERAL DIRECTOR Nalley Funeral Home Mt. Rainier, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 14 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 7a, b, Film GL 102 7 / MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) First Fred Middle Kembell Last						2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> Month 6 Day 23 Year 19 68		2b HOUR 11:05 a.m.			
3 SEX M		4 RACE Negro		5 DATE OF BIRTH 4 aug 1916		6 AGE (In years last birthday) 51 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) South Carol.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.					
10. CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DC				13b. COUNTY Washington		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1533 8th St., M.W.	
4 FATHER'S NAME First Middle Last				15. MOTHER'S M.A.DEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain											
DUE TO, OR AS A CONSEQUENCE OF (b) Trauma-struck by car											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Fractures rt tibia fibula, and femur.											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2 a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. 1:00 5-25-68 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Struck by a car.			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt 495 nr rt 214				21f LOCATION Street or R.F.D. No City or Town County State rural Prince George Md			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED 6-24-68			
EXAMINER'S NAME (Type)				ADDRESS							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE 6-27-68		23c NAME OF CEMETERY OR CREMATORY Lincoln Mem.		23d LOCATION (City or Town) County State		Sutton Md	
24. FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REG STRAR JUL - 1 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M RE

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Mary	Middle K.	Last Kennedy	2a. DATE OF DEATH Month 6 Day 12 Year 68			2b. HOUR : 00 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11/9/06		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges			Md		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Charles Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY C. J. Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Apt 210 7888 New Riggs Rd			
14. FATHER'S NAME Daniel			First Daniel	Middle Brady	Last Brady	15. MOTHER'S MAIDEN NAME Margaret			First Margaret	Middle Curry	Last Curry
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			(If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address William J. Kennedy Same as #13 Son				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 431.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One day											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11 June, 1968, to 12 June, 1968, that (I) (we) last saw the deceased alive on 12 June, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Dr. Kehoe notified											
22b. SIGNATURE C. J. Hermann				DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 12 June, 1968			
22d. PHYSICIAN'S NAME (Type) C. J. Hermann, M. D.				22e. ADDRESS Riverdale, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/14/68		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Montg. Md.					
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones				



CERTIFICATE OF DEATH

15

1. DECEASED NAME (Type or print) Joseph L. Ketterman		2a. DATE OF DEATH Month June Day 4 Year 1968		2b. HOUR 1.00AM
3 SEX Male	4. RACE White	5. DATE OF BIRTH 3 June 1968	6. AGE (In years last birthday) 75 YRS	IF UNDER 1 YEAR MONTHS 9
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges Md	
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen., Hosp.,	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Riverdale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6805 Riverdale Road Apt 1
14. FATHER'S NAME First Joseph Middle L Last Ketterman	15. MOTHER'S MAIDEN NAME First Joyce E. Middle Keiter Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO -----	17. INFORMANT Address Joseph L. Ketterman Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bromaturia & 7 days lie-down DUE TO, OR AS A CONSEQUENCE OF atelectasis of lungs disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congenital polycystic kidney, right. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Omphalocoele				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that xx (this hospital) attended the deceased from June 3, 1968 , to June 4, 1968 , that xx (we) last saw the deceased alive on June 4, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above xx (we) (did) not view the body after death.				
22b. SIGNATURE Bernardo Alvarado, M. D.	22c. DATE SIGNED June 4, 1968	22d. PHYSICIAN'S NAME (Type) Prince Georges General Hospital, Cheverly,		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/5/68	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) Cumber'nd Allegheny Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR JUN 7 1968	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

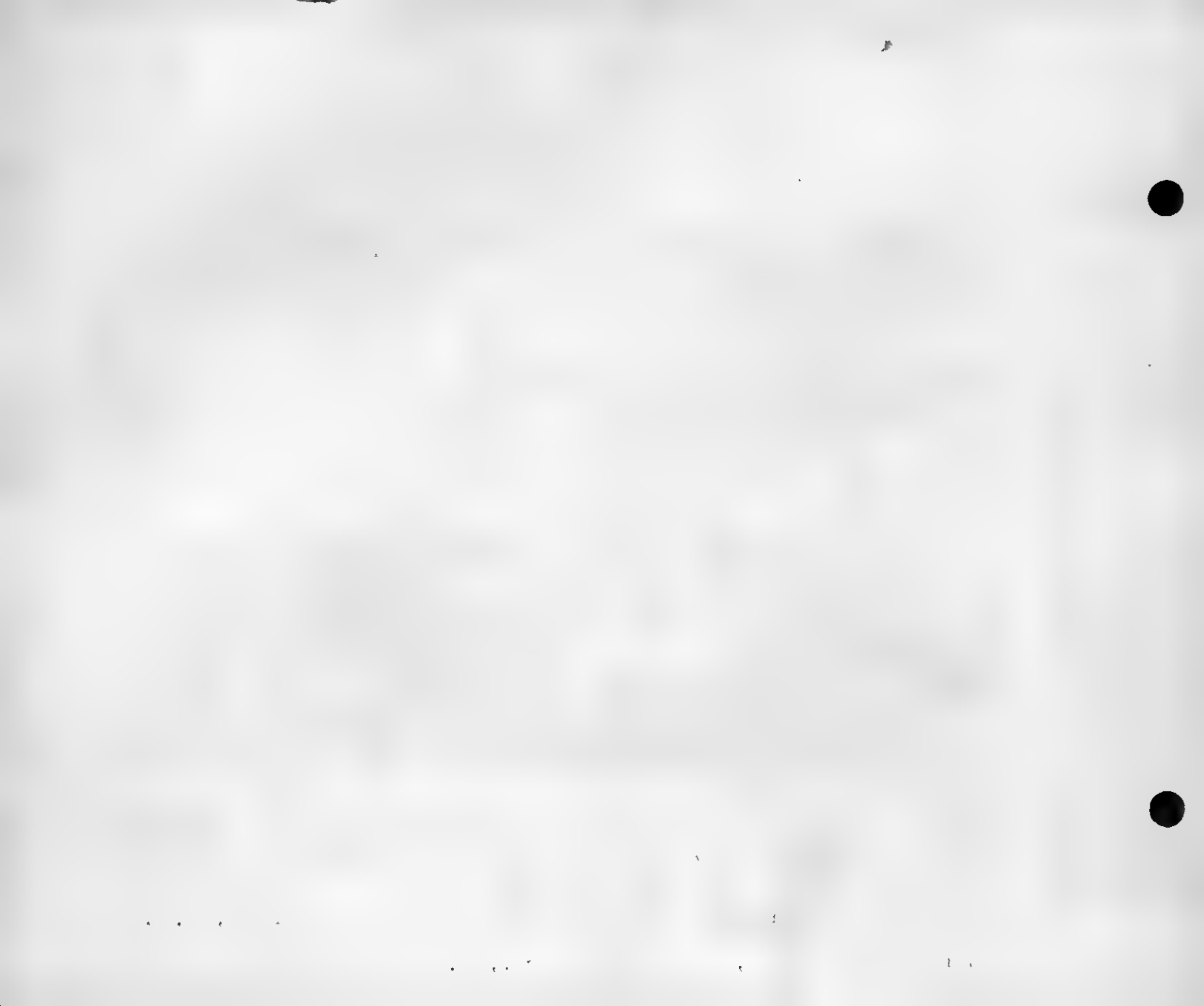
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MD-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print) Martin					2a DATE KNOWN OF DEATH 6 17 1968					
First Middle Last					Month Day Year					
3 SEX M					4 RACE W		5 DATE OF BIRTH 5 Jan 1899		6 AGE (In years) 69	
7a BIRTHPLACE (State or foreign country) Austria		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George		2d HOUR 3:50		
10 CITY OR TOWN OF DEATH Glendale		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Qtrs 6, Glendale Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Physician		12b KIND OF BUSINESS OR INDUSTRY Government		2d HOUR 3:50		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.		13b COUNTY Prince George		13c CITY OR TOWN Glendale		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER Qtrs 6, Glendale Hosp.		
14 FATHER'S NAME First Middle Last Unknown					15 MOTHER'S MAIDEN NAME First Middle Last Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16b SOCIAL SECURITY NO. 220-449764		17 INFORMANT Dr. Moe Weiss			
16c ADDRESS (Yes, no, or unknown) Glendale Hosp.					17 ADDRESS Glendale Hosp.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Asphyxia										
DUE TO, OR AS A CONSEQUENCE OF Hanging										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 14x										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Post-op carcinoma of rectum										
19a DATE OF OPERATION 1-Sept 67					19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 1-Carcinoma of rectum					
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					
21b TIME OF INJURY Month, Day, Year 2:30 19 63					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Lung self At home					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home					
21f LOCATION Street or RFD No Glendale Hosp., Glendale P.G.					City or Town Glendale County P.G. State Md.					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John Kehoe					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					22b DATE SIGNED 6-17-68					
ADDRESS (Street, city, town, or county) DC 20012					23a BURIAL, CREMATION, REMOVAL (Specify) Cremation					
23b DATE 18 June 1968					23c NAME OF CEMETERY OR CREMATORY Lee Crematory					
23d LOCATION (City or Town) Washington, D.C.					23e LOCATION (County) (State)					
24 FUNERAL DIRECTOR Rinaldi Funeral Home, 7400 Georgia Ave., N.W.					25a REC'D BY REGISTRAR JUN 20 1968					
ADDRESS DC 20012					25b REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 8, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mary		First Mary		Middle I.		Last Kilbreth		2a. DATE OF DEATH 6 ^{Month} 7 ^{Day} 68 ^{Year}		2b. HOUR 7:30	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10-14-84		6. AGE (In years last birthday) 83		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maine		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince George					
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) EXAMINER		12b. KIND OF BUSINESS OR INDUSTRY Boat Eng. U.S.					
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. CITY OR TOWN Prince George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6007-40th. Ave.			
14. FATHER'S NAME Luellen		First Luellen		Middle Keene		15. MOTHER'S MAIDEN NAME Addie		First Addie		Last Marshall	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ALBION L KILBRETH Address 4004 OLGETHORPE Son / and Medical Records HYATTSVILLE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GEN. ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) UNKNOWN										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUPPOSED UNKNOWN	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from JAN , 19 65 , to 7 JUNE , 19 68 , that (I) (we) last saw the deceased alive on 6 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE C. J. Houmann		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-7-68	
22d. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.		22e. ADDRESS 4404 Queensbury Rd., Riverdale, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10 JUNE 1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MD					
24. FUNERAL DIRECTOR W. W. Chambers		24b. ADDRESS 1300 Chapin St.		24c. CITY BALTIMORE		25a. REC'D BY REGISTRAR DATE JUN 11 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

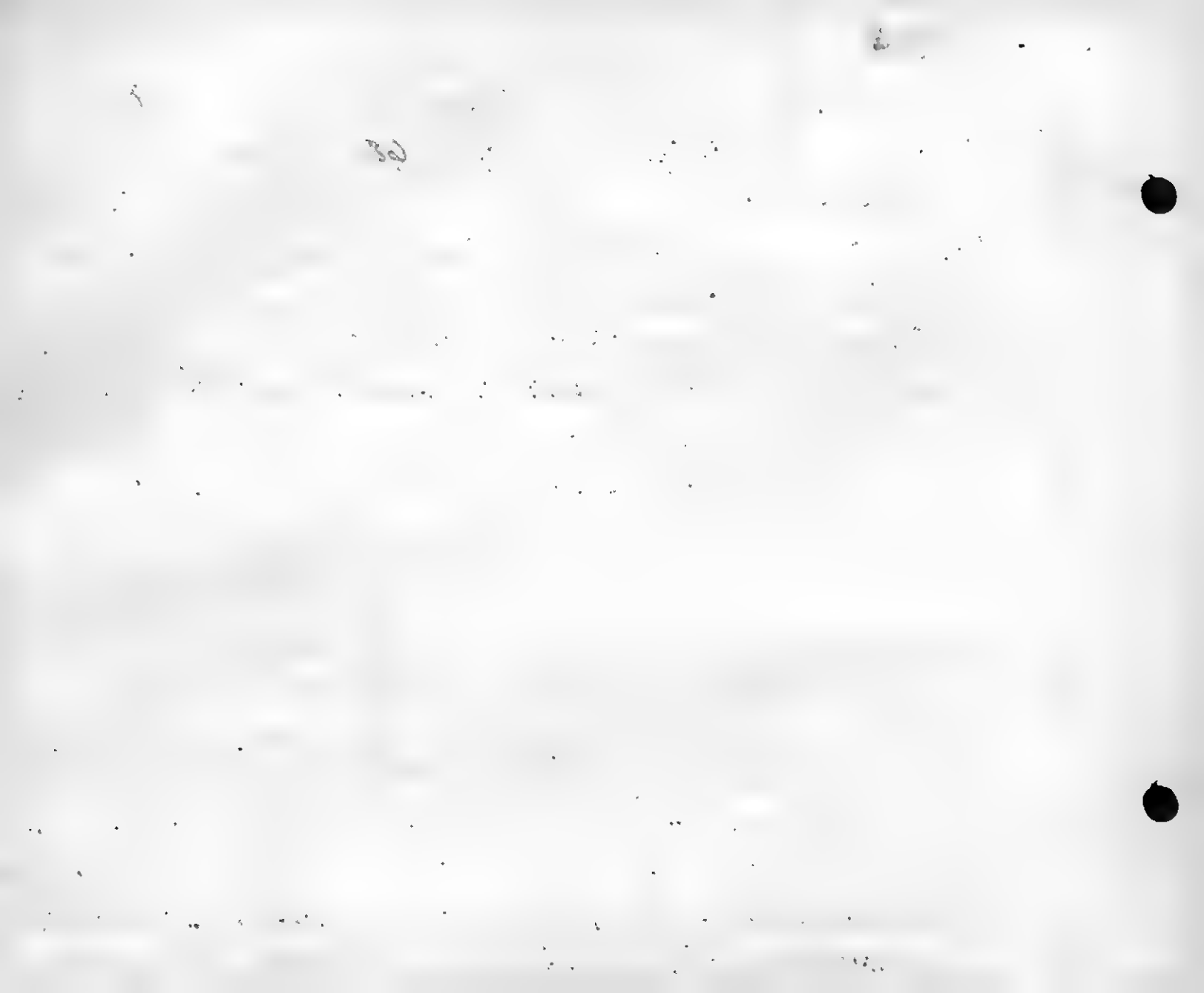
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) SYLvester R. King						2a. DATE OF DEATH Month JUNE Day 8 Year 1968			2b. HOUR 3:50 A M			
3. SEX M		4. RACE C		5. DATE OF BIRTH OCT-19-1918		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____		
7a. BIRTHPLACE (State or foreign country) DC		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PR. George's Md.						
10. CITY OR TOWN OF DEATH Cheverly, Md				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PR. Geo. Gen'l Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE M.D.				13b. COUNTY PR. GEO.		13c. CITY OR TOWN LANham		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6017 BARTON ST.		
14. FATHER'S NAME First JOHN Middle J Last KING						15. MOTHER'S MAIDEN NAME First EMMA Middle LACY Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ARMY				16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Exacerbating gastroenteritis for noxage from ruptured sigmoidal vessel DUE TO, OR AS A CONSEQUENCE OF 4549 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4710 Embolism of the liver (nutritional) with massive ascites												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____								
22a. I certify that (I) (this hospital) attended the deceased from JUNE 8, 1968 , to JUNE 8, 1968 , that (I) (we) last saw the deceased alive on JUNE 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE U.K. Ho Lee						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED JUNE-9-68				
22d. PHYSICIAN'S NAME (Type) U.K. Ho Lee						22e. ADDRESS PR. Geo. Gen'l Hosp. Cheverly Md.						
23a. BURIAL, CREMATION, REM. JVAL (Specify)		23b. DATE 6-14-68		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial				23d. LOCATION (City or Town) (County) (State) 4001 - Suitland Rd. Suitland				
24. FUNERAL DIRECTOR C.V. Lewis Funeral Home 1141-22nd St						ADDRESS		25a. REC'D BY REGISTRAR JUN 12 1968		25b. REGISTRAR'S SIGNATURE Charles Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR
ANNA					KIRN	6 Month 22 Day 68 Year			3:50 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS
FEMALE		WHITE		4/22/90		78 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
GERMANY		U.S.A.				PRINCE GEORGE CO. Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
ADELPHI		3120 POWDER MILL RD. BETHESDA, MD.		HOUSEWIFE		AT HOME			
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD.		HOWARD CO.		JESSUP		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
HERMAN					WINTER	MARGARET			WILLMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>glomerulonephritis (nephritis)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 1/2 wks.</u>		
NO			218-32-2162		MRS. DOROTHY VANDEUSEN		4841 LINCOLN AVE. BELTSVILLE, MD.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 2-21, 1968, to 6-22, 1968, that (I) (we) last saw the deceased alive on 6-21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)			
R.D. Bauer, M.D.		6-22-68				R.D. Bauer, M.D.			
22e. ADDRESS		22f. REGISTRAR'S SIGNATURE							
2513 Buck Lodge Rd. Adelphi, Md.		Charles Judge							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		County	State
CREMATION		6-24-68		FT. LINCOLN CR.		COLMAR MANOR R. GEO. MD.			
24. FUNERAL DIRECTOR									
W.W. CHAMBERS CO. 5801 E. CLEVELAND RIVERDALE, MD.									
25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
DATE JUN 25 1968					Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

68919

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

68920

1. DECEASED NAME (Type or print) First Middle Last ESTELLA A KOEPKE			2a. DATE OF DEATH Month Day Year 6 27 68			2b. HOUR 4:30 P.M.	
3. SEX FEM		4. RACE WHITE		5. DATE OF BIRTH 8/27/87		6. AGE (In years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES. Md.	
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MAGNOLIA GARDENS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME.	
13a. U.S. AL. RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE MD.		13b. COUNTY PRINCE GEORGE.		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last R. H. BAKER		15. MOTHER'S MAIDEN NAME First Middle Last ESTELLE CONSTOCK		13e. STREET AND NUMBER 802 KAY COURT, LAUREL, MD.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) NO		16b. SOCIAL SECURITY NO. 1		17. INFORMANT Mrs ALBEATA McKINNEY		Address SAME 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (b) ARTERIOSCLEROTIC CORONARY ARTERY DISEASE stating the underlying cause (c) GENERALIZED ARTERIOSCLEROSIS. last 1-1						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 HRS 10 YRS 10 YRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROTIC & THROMBOTIC CEREBRAL VASCULAR DISEASE.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 17 JUNE, 1968 to JULY 19 68 , that (I) (we) last saw the deceased alive on 22 JUNE 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 22 June 1968	
22d. PHYSICIAN'S NAME (Type) LANHAM		22e. ADDRESS MD.					
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE June 20/68		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY		23d. LOCATION (City or Town) (County) (State) ELK RIDGE, Howard MD.	
24. FUNERAL DIRECTOR [Signature]		ADDRESS 550 WASH BVD		25a. RECEIVED BY REGISTRAR MD		25b. REGISTRAR'S SIGNATURE [Signature]	

JUL - 1 1968

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) Melvin Price Lamkin			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 6 Day 6 Year 68			2b. DATE PRONOUNCED DEAD Month 6 Day 6 Year 68	
3 SEX Male	4. RACE White	5. DATE OF BIRTH 12-29-14	6. AGE (n years last birthday) 53 YRS	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS HOURS _____ MIN _____	2c. DATE PRONOUNCED DEAD Month 6 Day 6 Year 68	
7a. BIRTHPLACE (State or foreign country) Wash., DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's	
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Reporter - Dunn & Bradstreet	
13a. USJA. RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Md.			13b. COUNTY P.G.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME John W. Lamkin			15. MOTHER'S MAIDEN NAME Lena H. Miller			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	
16b. SOCIAL SECURITY NO. WW-11			17. INFORMANT Fay Satterfield - 5815 - 32nd Ave. Hyattsville Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.O. No. _____ City or Town _____ County _____ State _____			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 6-8-68	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS (Street, city, town, or county)							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE June 10-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.				ADDRESS 1111-Cd. Hope Rd. SE. DC		25a. REC'D BY REGISTRAR DATE JUN 10 1968	
25b. REGISTRAR'S SIGNATURE Charles J. Jones							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-43. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 1968												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																							
1 DECEASED-NAME (Type or Print)				First Winifred				Middle Eileen				Last Leyden				2a DATE KNOWN OF DEATH ESTIMATED Month 6 Day 19 Year 1968				2b HOUR 10:30 A.M.			
3 SEX F		4 RACE W		5 DATE OF BIRTH 8 Oct 1921		6 AGE (In years last birthday) 46 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month 6 Day 19 Year 1968				2d HOUR 12:00 noon							
7a BIRTHPLACE (State or foreign country) New York				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince George Md											
10 CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George								12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife				12b KIND OF BUSINESS OR INDUSTRY Home							
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Virginia				13b COUNTY Fairfax				13c CITY OR TOWN Fairfax				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER 9313 Hamilton Drive							
14. FATHER'S NAME First Middle Last Charles Weeks				15 MOTHER'S MAIDEN NAME First Middle Last Lorraine Boyer				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no								16b SOCIAL SECURITY NO. 106-16-6325				17. INFORMANT ADDRESS William G. Leyden-9313 Hamilton Dr. Fairfax, Va			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8120 DUE TO, OR AS A CONSEQUENCE OF Occipital skull fractures (b) DUE TO, OR AS A CONSEQUENCE OF Bilateral hemothorax from multi-rib fractures (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b TIME OF INJURY Month, Day Year HOUR A.M. 6 19 68						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) Driver of car involved in collision											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e PLACE OF INJURY (At home farm, street, factory, office building, etc.) Rt 495						21f LOCATION Street or R.F.D. No. City or Town County State Marlboro PG. Md.											
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL EXAMINER'S SIGNATURE John Kehoe, M.D., Riverdale						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b DATE SIGNED 6-19-68											
23a BURIAL, CREMATION, REMOVAL (Specify) Burial						23b DATE 6/24/68		23c NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.				23d LOCATION (City or Town) (County) (State) Arlington, Virginia											
24. FUNERAL DIRECTOR 1102 Broad Street Falls Church Funeral Home, Falls Church, Va																							

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-6. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First Middle Last Henrietta Loebstern										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 6 7 1968		2b. HOUR MIN 4:10 M					
3 SEX female		4 RACE white		5. DATE OF BIRTH 12-14-1915		6 AGE (in years last birthday) 52 YRS.		7 UNDER YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 6 7 1968		2d. HOUR MIN 11 M					
7a. BIRTHPLACE (State or foreign country) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD.				13b. COUNTY P.G.				13c. CITY OR TOWN HYATSVILLE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3450 TOLDO TEXAS AVE			
14 FATHER'S NAME First Middle Last HERMAN ROTHENBERG						15. MOTHER'S MAIDEN NAME First Middle Last JENNIE COHEN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. 131-07-6981				17. INFORMANT MAX LOEBSTERN				ADDRESS 801 ME A5 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown overdose of barbiturate</u> 9500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR MIN 2:00 PM 6-7 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Ingested overdose of barbiturate									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. City or Town County State Bladenburg PG Md									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE John Kehoe				EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 6-7-68					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 6-10-1968				23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK				23d. LOCATION (City or Town) (County) (State) FALLS CHURCH VA.					
24. FUNERAL DIRECTOR GOLD BECK FUNERAL HOME				ADDRESS 4217 9TH ST. N.W.				25a. REC'D BY REG. STRAR DATE JUN 11 1968				25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

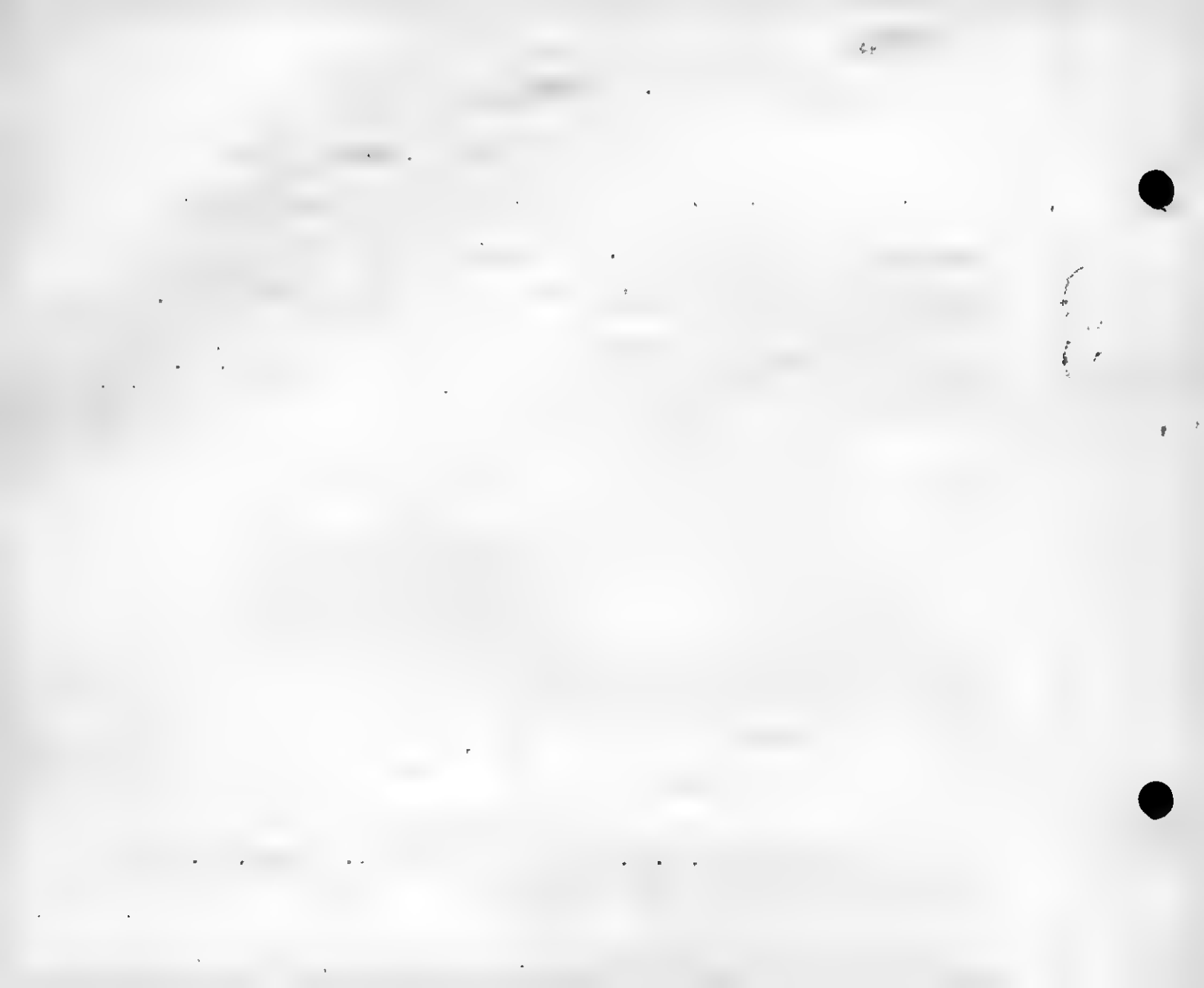
1 DECEASED-NAME (Type or print) First Middle Mary Elizabeth		2a DATE OF DEATH Month Day Year June 26 68		2b HOUR P 6:15 M
3 SEX Female	4 RACE White	5 DATE OF BIRTH Sept. 10, 1880	6 AGE (In years lost birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Wash., D. C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince Georges Md.	
10 CITY OR TOWN OF DEATH Hyattsville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Supervisor	12b KIND OF BUSINESS OR INDUSTRY Bur. of Eng.	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.	13b COUNTY Pr. Geo.	13c CITY OR TOWN College Pk.	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 9222 Woffard Lane
14 FATHER'S NAME First Middle Last William A. Loeffler	15 MOTHER'S MAIDEN NAME First Middle Last Mary Stafford			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown	16b SOCIAL SECURITY NO. -	17 INFORMANT Address Mary W. Unsworth, Niece, same as item #13e		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X (b) Cerebral Arteriosclerosis & Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) 2+ years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arrhythmia of Ventricles				
19a DATE OF OPERATION June 26, 1968	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Arrhythmia of Ventricles	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or RFD No City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from Apr 1967 to June 26, 1968 , that (I) (we) last saw the deceased alive on June 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE Richard F. Shaw M.D.	DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED 6-26-68	
22d PHYSICIAN'S NAME (Type) RICHARD F. SHAW	22e ADDRESS 1324 - Mich. Ave NE DC			
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE 6-29-1968	23c NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave N.W., Wash., D.C., 20016		25a REC'D BY REGISTRAR JUL - 1 1968	25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the birth papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Marguerite Middle M. Last Luers			2a. DATE OF DEATH Jan. Month 9 Day 1968			2b. HOUR 3:35 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH June 16, 1882		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12900 Tenth St.	
14. FATHER'S NAME Francis First Mickey Middle Sarah Last			15. MOTHER'S MAIDEN NAME E. Charters First E. Middle Charters Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown) no		16b. SOCIAL SECURITY NO 212 01 4351		17. INFORMANT Edna M. Davisson		530 St. S. W. Washington D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Statis Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Haemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) High Blood pressure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 34 days 5 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.O. No City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from July, 1958 , to June 7, 1968 , that (I) xxx saw the deceased alive on June 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death									
22b. SIGNATURE Robert M. McConney				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/9/68			
22d. PHYSICIAN'S NAME (Type) Robert McConney, M. D.				22e. ADDRESS 402 Main St., Laurel, Md. 20810					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/12/68		23c. NAME OF CEMETERY OR CREMATORY Holy Trinity		23d. LOCATION (City or Town) (County) (State) Collington P.G. Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



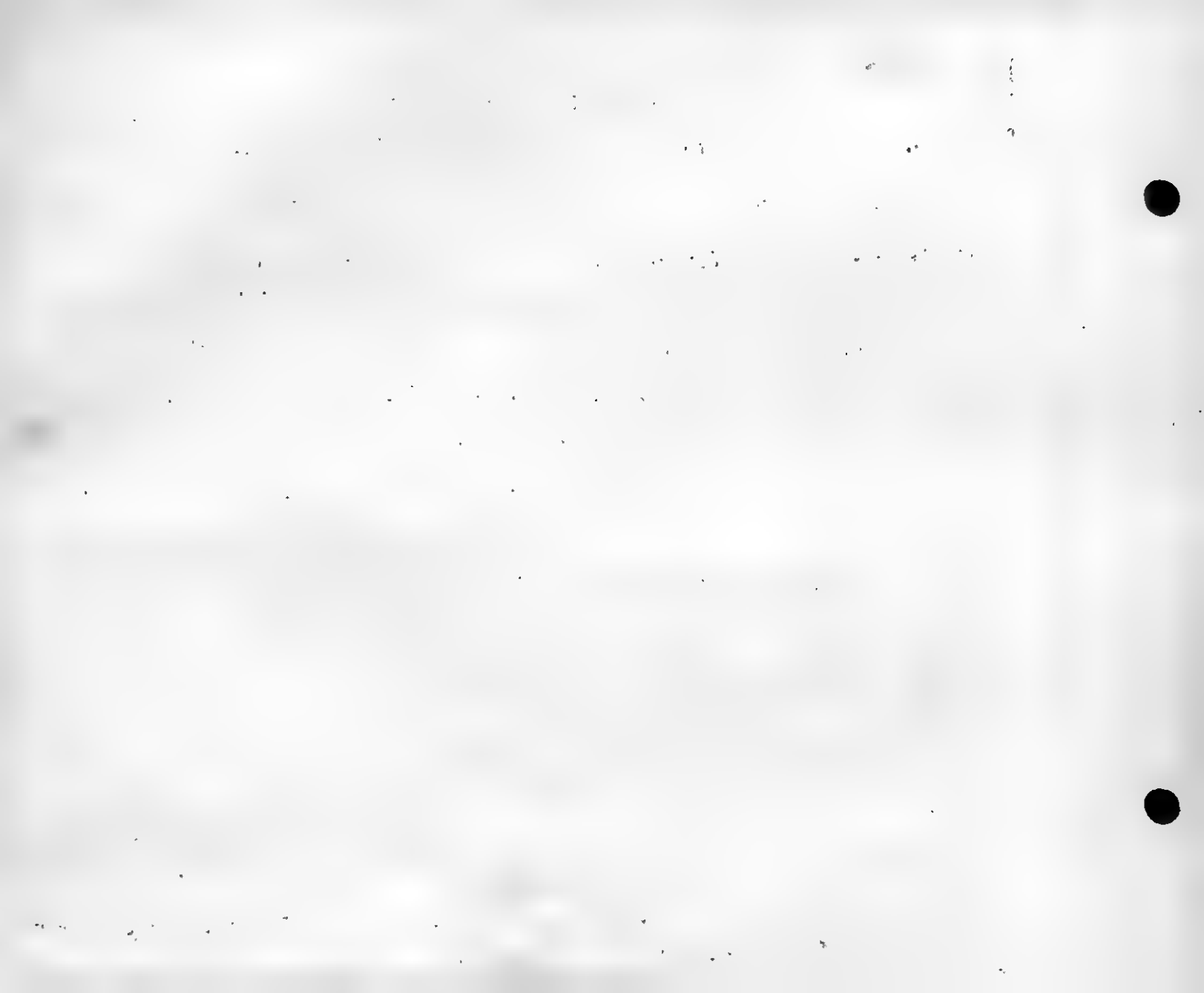
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If in please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Mary Elizabeth MacCormac			2a. DATE OF DEATH Month June Day 20 Year 1968			2b. HOUR 8 A M								
3 SEX Female		4 RACE White		5 DATE OF BIRTH Apr. 14, 1878		6 AGE (In years last birthday) 90 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS 		8 IF UNDER 24 HRS. HOURS MIN. 				
7a. BIRTHPLACE (State or foreign country) California			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George Md.					
10 CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Manor			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Registered Nurse			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia			13b. COUNTY Arlington			13c. CITY OR TOWN Arlington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1701 Kent St.		
14 FATHER'S NAME First George Middle Last Birdsall			15 MOTHER'S MAIDEN NAME First Mary Middle Elizabeth Last Hart			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 231 70 3536			17 INFORMANT Kenneth MacCormac Address Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Generalized Arteriosclerosis & Debility DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 dA 5 Yrs				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Severe Rheumatoid Arthritis & Chronic Myeloneuritis														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOMY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1964 , 19 , to 6-20-68 , 19 68 , that (I) (we) last saw the deceased alive on 6-19-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Richard B. Perry MD			DEGREE 			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 6-20-68					
22d. PHYSICIAN'S NAME (Type) RICHARD B. PERRY MD			22e. ADDRESS 2001-eye ST NW WASH DC											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6-22-68			23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery			23d. LOCATION (City or Town) (County) (State) San Francisco California					
24 FUNERAL DIRECTOR Francis J. Collins			ADDRESS 3821 14th St., N. W. Washington, D. C.			25a. REC'D BY REGISTRAR JUN 21 1968			25b. REGISTRAR'S SIGNATURE Richard J. Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR			
MABEL - MAHAFFEY						June 7 1968		7P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
FEMALE		CAUCASIAN		5/8/82		86 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
PA.		U.S.A.				PRINCE GEORGE COUNTY Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
LANHAM		MAGNOLIA GARDENS (W)		HOUSE WIFE		Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, APTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.					BRENTWOOD		YES		3808 WEBSTER ST.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S M A DEN NAME First			Middle	Last	
James					Blackstock	Sarah				Howe	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT				Address	
no			218-30-25908			William N. Mahaffey				Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial heart failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)											
21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1968</u> , to <u>June 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William R. Greco, M.D.</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>											
22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (Type) William R. Greco, M.D.											
22e. ADDRESS 6201 Riverdale Rd. Riverdale, MD.											
23a. BURIAL, CREMATION REMOVA. (Specify) Burial											
23b. DATE 6/4/68											
23c. NAME OF CEMETERY OR CREMATORY Mt. Airy											
23d. LOCATION (City or Town) (County) (State) Nartona Heights Pa											
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.											
25a. REC'D BY REGISTRAR DATE JUN 4 1968											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First Melvin	Middle G.	Last Marlow	2a. DATE OF DEATH Month Day Year June 16 1968			2b. HOUR 11:15A		
3 SEX Male		4. RACE Negro		5. DATE OF BIRTH 2/10/1923		6. AGE (In years last birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) N. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges			Md		
10. CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Maintenance Man		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash., D.C.		13b. COUNTY D.C.		13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 512 You St., N. W.			
14. FATHER'S NAME First Middle Last John -- Marlow			15. MOTHER'S MAIDEN NAME First Middle Last Emma -- Stanley								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No			16b. SOCIAL SECURITY NO. 246-18-9751		17. INFORMANT Address Decedent						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Probable ventricular fibrillation (clinical) DUE TO, OR AS A CONSEQUENCE OF (b) coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) unknown										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden	
										unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary tuberculosis.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/10/ 19 68 , to 6/16/ 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6/16/ 19 68 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death.											
22b. SIGNATURE Moe Weiss						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/16/1968			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.						22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-21-1968		23c. NAME OF CEMETERY OR CREMATORY (shipped) Little Prong M. Bapt Church		23d. LOCATION (City or Town) (County) (State) Ash, N. C.					
24. FUNERAL DIRECTOR Malvina Schreyer						25a. REC'D BY REGISTRAR DATE JUN 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

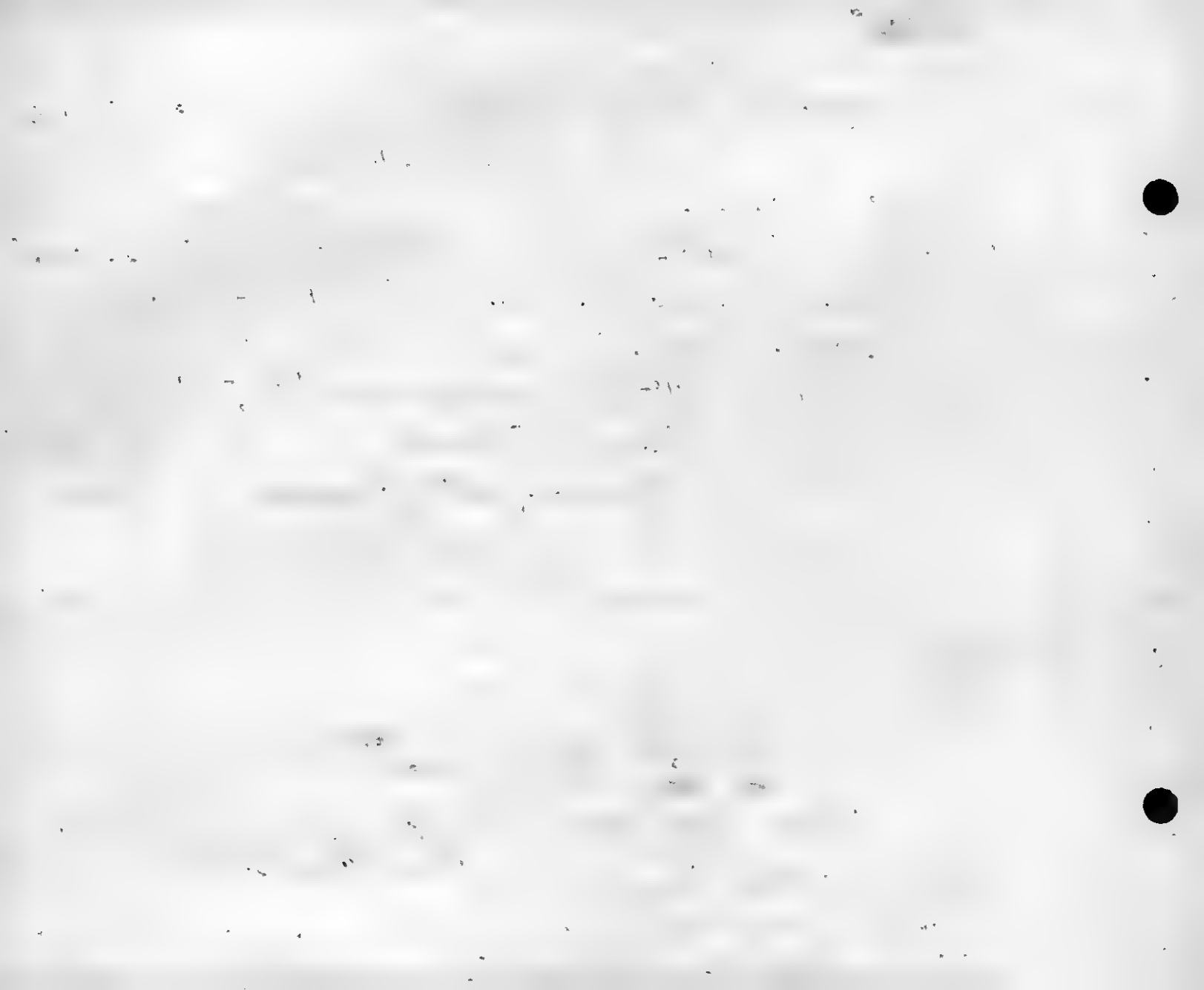
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR
Samuel L. Matthews						DATE MATED <input checked="" type="checkbox"/> 6-16-68			19	12	50pm	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male	White	4-8-1916	52 YRS					6 Month 16 Day 68 Year			191:06pm M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Alabama		U.S.A.				Prince George's Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work pg life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Choverly			Prince George Hospital			Saxtonian			Chemical Eng			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIM 15?		13e. STREET AND NUMBER		
Maryland			Prince George's Landover Hills			YES <input type="checkbox"/> NO <input type="checkbox"/>				7014 Barton Road		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Samuel L						Joseph						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
			577-014384			Bliss Matthews			Same as			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of head												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			12:50pm 6-16-19 68			Shot self with .22 cal. rifle.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No			City or Town County State			
			home			same as # 13						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED
John Kehoe MD			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			6-17-68
23a. BURIAL (CREMATION, REMOVAL) (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			6/20/1968		Fairview			Prince Georges Md				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Robert A. Mattingly			1317 1/2 St NW			JUN 18 1968			Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Orville Clark McBride			2a. DATE OF DEATH Month Day Year 6 13 1968			2b. HOUR 9:10 AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH June 29, 1895		6. AGE (In years last birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) Crane, Missouri		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 13108 - 13th Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Entomologist		12b. KIND OF BUSINESS OR INDUSTRY Dept. of Ag.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Bowie		13e. STREET AND NUMBER 13108 - 13th Street	
14. FATHER'S NAME First Middle Last E. Harry McBride		15. MOTHER'S MAIDEN NAME First Middle Last Anna Shockley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) yes		16b. SOCIAL SECURITY NO 215-38-4081		17. INFORMANT Beatrice McBride Bowie, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) minutes Approximate interval between onset and death years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/27 , 19 68 , to 6/13 , 19 68 , that (I) (we) last saw the deceased alive on 5/27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (saw) view the body after death.							
22b. SIGNATURE H. James Kurtz M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/13/68	
22d. PHYSICIAN'S NAME (Type) H. James Kurtz		22e. ADDRESS RFD Glenn Dale Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE June 14, 1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR JUN 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



28926

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Daniel Edward McCarthy			2a. DATE OF DEATH June Month 3 Day 1968			2b. HOUR 6 p M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 2nd 1901		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Wash, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Prince Geo		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7117 Buchanan Street	
14. FATHER'S NAME First Middle Last Michael Joseph McCarthy		14. MOTHER'S MAIDEN NAME First Middle Last Catherine Dawson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Josephine McCarthy Same as 13 abcde					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute myocardial infarction</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 weeks</u> <u>2 weeks</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1968</u> to <u>3 Jun 1968</u> , that (I) was saw the deceased alive on <u>3 Jun 1968</u> , and that (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did (did not) view the body after death.									
22b. SIGNATURE <u>Thomas J. Maloney</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3 Jun 68</u>			
22d. PHYSICIAN'S NAME (Type) Thomas J. Maloney				22e. ADDRESS 4814 71st Ave Hyattsville, Md					
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE <u>6-6-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MA Orlan</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash D.C.</u>			
24. FUNERAL DIRECTOR <u>Robert A Mattingly</u>		ADDRESS <u>131-1124 St</u>		25a. REC'D BY REGISTRAR DATE JUN 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

Item 7a, b, Film 402 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI DEATH MATED			Month Day Year			2b HOUR PM			
Joseph H. McDermott						6 22 1968						2:00 PM			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER MONTHS	8 UNDER YEARS	9 UNDER 24 HRS HOURS	10 UNDER 24 HRS MIN.	2c DATE PRONOUNCED DEAD			2d HOUR				
M	W	25 April 1910	58 YRS					Month 6 Day 22 Year 1968			6:00				
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH						
Iowa			USA						Prince George			Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY						
Laurel			Diner Motel			Engr.			Electrical						
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Md.			Prince George			Marlowe Heights			NO <input checked="" type="checkbox"/>			1921 Brooks Drive			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME												
Peter McDermott			Elizabeth Martindale												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			579 07 1464			Sarah T McDermott			1921 Brooks Dr.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u>												Min.			
129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u>												unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>and Acute Alcoholism</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)															
19a. DATE OF OPERATION															
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
CAUSE OF DEATH			19												
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office build'g, etc.)			21f LOCATION Street or R.F.D. No			City or Town			County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			John Kehoe, Riverdale			ADDRESS (Street, city, town, or county)			6-23-68						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			(County) (State)			
Burial			6-26-1968			Cedar Hill Cemetery			Suitland, Maryland						
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Walley Funeral Home			Mt. Rainier, Md.			DATE JUN 27 1968			Charles Judge						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

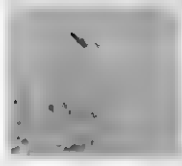
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
Paul		E		McFarland				DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 6-7-68		193:30pm	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	8-23-1918	49 YRS	MONTHS		DAYS		Month 6 Day 7 Year 68		4:30pm	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wash., D.C.		U S A		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Prince George's				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Mt. Rainier		3303 Chillum Road		Mechanic		Vending					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Prince George's		Mt. Rainier		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3303 Chillum Road			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Harvey		L.		McFarland				Maude		M. Edwards	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
Yes		WWII		718 14 9919		Maude M. McFarland		same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF <u>Bronchogenic carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 4 mo. over 4 mo.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>1621</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6-9-68	
								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
								ADDRESS (Street, city, town or county)			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		June 10 1968		Pt. Lincoln Cemetery		Colmar Manor		Maryland			
24. FUNERAL DIRECTOR				ADDRESS				25a. REG. BY REGISTRAR 1968 REGISTRAR'S SIGNATURE			
Nalley Funeral Home				Mt. Rainier, Md.				DATE JUN 11 1968			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First KATHARINE		Middle D.		Last McGINNIS		2a. DATE OF DEATH Month <u>2</u> Day <u>68</u> Year	
3 SEX Female		4 RACE CAU		5. DATE OF BIRTH 30 Dec 1899		6 AGE (In years last birthday) 68 YRS.		2b HOUR 0330	
7a BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George			
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital) USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DC		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2911 Cathedral Ave NW	
14. FATHER'S NAME Thomas		First F.		Middle Durham		15. MOTHER'S M.A.DEN NAME Mathilde		Informant could not recall middle name WILLIAM	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give we dates of service) No		16b. SOCIAL SECURITY NO 578-62-2049		17. INFORMANT Harold A. McGinnis, 2911 Cathedral Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypoxemia.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Lung Disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Car (Adeno) R Lung.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <u>None</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>2 June 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John F. Lindeman</u>		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2 June 68</u>	
22d. PHYSICIAN'S NAME (Type) John F. Lindeman MD		22e. ADDRESS USAF HOSPITAL ANDREWS AFB							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-5-1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington County, Virginia			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Wash., D.C., 20016		ADDRESS 5130 Wisc. Ave		25a. REC'D BY REGISTRAR DATE JUN 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR			
James Bernard McKenna						Month Day Year			6 2 19 68			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR		
M	W	4 Feb., 1898	70 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year	6 2 19 68		2:00 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Penn.		USA				Prince George Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale			Leland Memorial			steelworker			steel mill			
13a. USUAL RESIDENCE (Where deceased lived, if at institution on admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY, APTS?			
Md.			Prince George			Laurel			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S M.A.DEN NAME			13e. STREET AND NUMBER						
James McKenna			Ellen McKenna			200 11th St.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
						Mrs James McKenna - above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Heart failure		Min.
4129 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										Arteriosclerotic heart disease		over 2 yrs.
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
4210 Diabetes mellitus-over 2 yrs.												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
				HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED				
EXAMINER'S NAME (Type)				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				6-2-68				
John Kehoe, M.D., Riverdale				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		6-5-68		St Marys Cem		Laurel Md.						
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
DelWitt Danielson				DATE JUN 6 1968				J. Charles Young				



FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Harry Lewis Meyer						MAY 6-17-68		13:01pm		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR		
Male	White	11 June 1927	41 YRS			Month 6 Day 17 Year 68		4:15pm		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna.		U.S. A.				Prince George's Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Insurance Agent		INSURANCE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Prince George's		Bowie		YES <input type="checkbox"/> NO <input type="checkbox"/>		3802 Corbett Place	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last Harry Raymond Meyer			First Middle Last Charlotte Fulton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT					
Yes			162-20-7101		Mrs. Ruth E. Meyer 3802 Corbett Pl. Bowie Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Compound skull fracture, left temporal area</u>										
DU TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DU TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
8164										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
CAUSE OF DEATH		3:00pm 6-17-19 68		Driver of car involved in collision.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
		Rt. 450, Bowie, Prince George's County, Maryland								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			6-18-68				
John Kehoe MD Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		June 21, 1968		Penn Memorial Garden Cem.		Pittsburg,		Pa.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Warner E. Pumphrey, Inc., 8434 Ga. Ave. S.S.				DATE JUN 25 1968		Charles Judge				



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) Robert E. MILLER			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month June Day 27 Year 1968			2b HOUR M			
3 SEX Male	4 RACE White	5 DATE OF BIRTH Oct 10 1949	6 AGE (in years last birthday) 18 YRS.	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN 	2c DATE PRONOUNCED DEAD Month June Day 27 Year 1968		2d HOUR M	
7a BIRTHPLACE (State or foreign country) Florida		7b CIT ZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges			
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b KIND OF BUSINESS OR INDUSTRY of Maryland			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE FLA		13b COUNTY DADE		13c CITY OR TOWN MIAMI		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 18601 SW 97th	
14. FATHER'S NAME First Lloyd Middle E. Last Miller			15. MOTHER'S MAIDEN NAME First Ruth Middle Last Clark						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO 		17 INFORMANT Lloyd E. Miller Same as #13			ADDRESS 		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Cerebral Contusions & Laceration - instant - Cond't ions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Sub. asphyxia & Hemorrhage - Fractures PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8157								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instant	
19a. DATE OF OPERATION 8194				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 5:30 AM June 27 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) automobile accident					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION Street or R.F.D. No. Little Patuxent Bridge, Anne Arundel Md					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Dayton O Watkins		EXAMINER'S NAME (Type) DAYTON O WATKINS		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, county, state) 5518 Annapolis Rd, Hyattsville, Md		22b DATE SIGNED 6-27-68			
23a BURIAL, CREMATION, REMOVAL (Specify) Removal		23b DATE 6/28/68		23c NAME OF CEMETERY OR CREMATORY Stanfield Funeral Home		23d LOCATION (City or Town) Miami Dade Fla			
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				ADDRESS 		25a REC'D BY REGISTRAR JUL - 2 1968		25b REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Roy Edward Mock					2a. DATE OF DEATH Month Day Year June 26 68		2b. HOUR 7:02A		
3. SEX Male		4 RACE Cau		5. DATE OF BIRTH 3 May 25		6. AGE (In years last birthday) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Arizona		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Officer, USAF		12b. KIND OF BUSINESS OR INDUSTRY USAF			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 5609 Eastwood Court	
14. FATHER'S NAME First Middle Last Thurmond Mock			15. MOTHER'S MAIDEN NAME First Middle Last Lettie Arnold						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO. 526-22-3290		17. INFORMANT Address Wife 5609 Eastwood Ct, Clinton, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) xx								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the cause as stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. Staples		DEGREE CAPT		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 26 June 68			
22d. PHYSICIAN'S NAME (Type) GARY S. STAPLES		22e. ADDRESS Malcolm Grow USAF Hospital Andrews AFB, Md. 20331							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 6-28-68		23c. NAME OF CEMETERY OR CREMATORY Falls Church Funeral Home, Falls Church, Va		23d. LOCATION (City or Town) (County) (State) Phoenix, Arizona			
24. FUNERAL DIRECTOR Falls Church Funeral Home, Falls Church, Va		ADDRESS		25a. REC'D BY REGISTRAR JUN 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
Leonard Wakefield Morris						Month Day Year		6-10-68 19 8:51pm		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR		
Male	Negro	3-12-1914	54 YRS	MONTHS DAYS	HOURS MIN.	Month Day Year		6 10 68 19 1:13pm		
7a. BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY		
Virginia		U.S.A.				Prince George's		Weather Bureau		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		12c WEATHER		
Cheverly		Prince George Hospital		Clerk						
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
District of Columbia			Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3909 Mass. Ave., S.E.			
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
David Morris			Ora Williams							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
NONE			NO		Marie H. Morris-3989 Massachusetts Ave. SE					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock										
DUE TO, OR AS A CONSEQUENCE OF Bilateral hemothorax										
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost										
(b) and laceration of heart										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			8:50 PM 6-10-19 68		Driver of car involved in collision					
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Anacostia River Bridge		Balt. Wash. Parkway		Prince George Co.				
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
John Kehoe MD			Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6-12-68		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)		
Burial		6-14-68		Lincoln Memorial		Suitland		Maryland		
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
John T. Rhines Co. 3015 12th Street, N. E. Funeral Home Washington, D. C. 20017				DATE JUN 17 1968		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

029335

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Richard E. Morrissey			2a. DATE OF DEATH Month 11 Day 29 Year 68			2b. HOUR 9 45 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-14-01		6. AGE (In years last birthday) 66 YRS	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Magnolia Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RET. FOREIGN SERV.		12b. KIND OF BUSINESS OR INDUSTRY STATE DEPT.	
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE Md.		13b. COUNTY Prince George		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 9105 Woodside Court		14. FATHER'S NAME First Michael Middle Morrissey Last Ellen		15. MOTHER'S MAIDEN NAME First Ellen Middle Moore Last Moore		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) -	
16b. SOCIAL SECURITY NO. 121-09-5389		17. INFORMANT Mr. Gerald E. Morrissey - above ad-		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Lung DUE TO, OR AS A CONSEQUENCE OF (b) Generalized metastasis DUE TO, OR AS A CONSEQUENCE OF (c) 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mths 3 mths	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-2 , 19 68 , to 6-29 , 19 68 , that (I) (we) last saw the deceased alive on 6-29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) HOEING	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/2/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION (City or Town) (County) (State) Wash. D.C.	
24. FUNERAL DIRECTOR HALL'S FUNERAL HOME INC.				25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

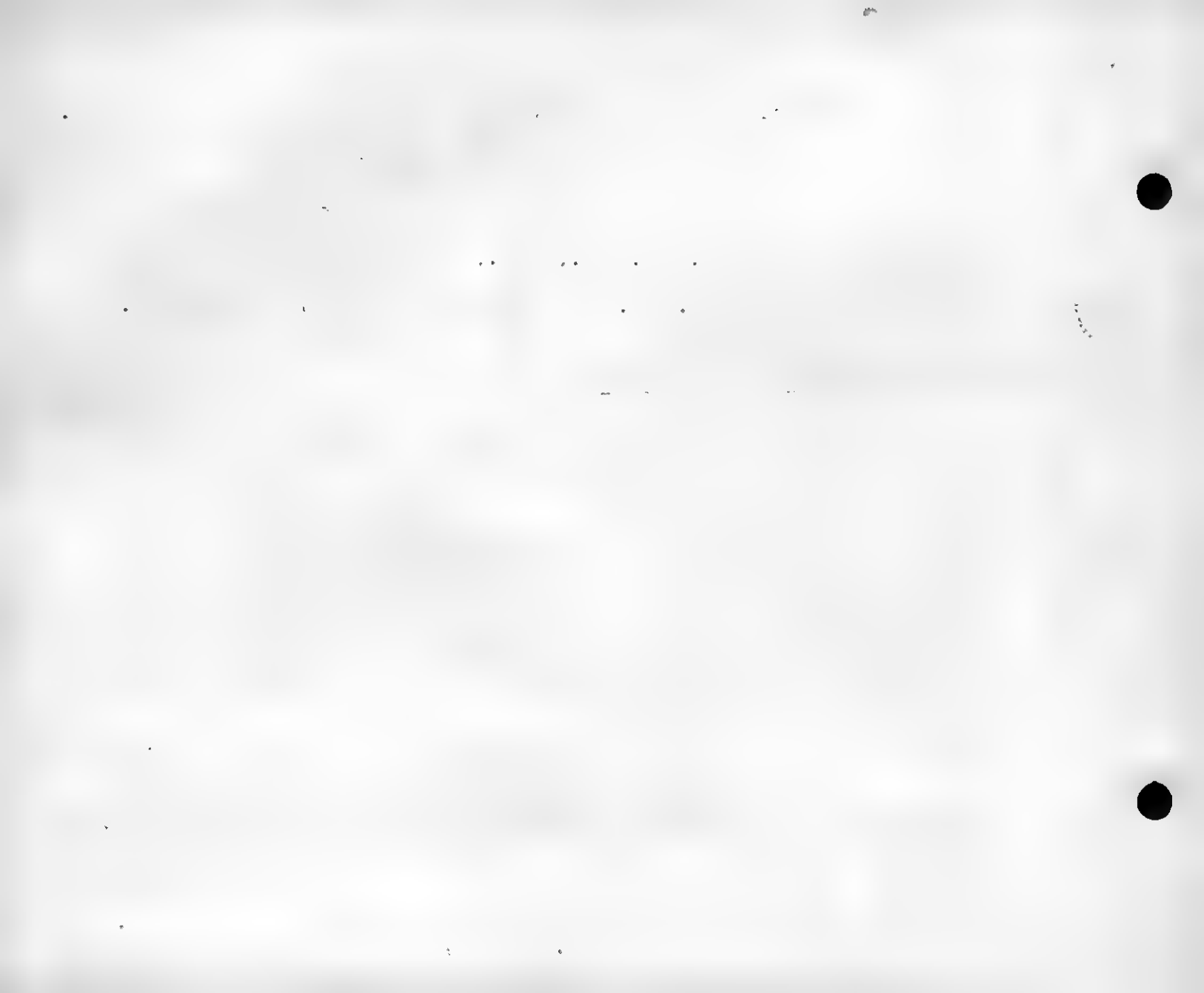
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) BESSIE MAE MORTIMER			2a. DATE OF DEATH Month 6 Day 11 Year 1968			2b. HOUR M	
3. SEX FEMALE		4. RACE W		5. DATE OF BIRTH 1/17/81		6. AGE (In years last birthday) 87 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.	
10. CITY OR TOWN OF DEATH FORESTVILLE Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home Maryland Pike		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased, ved, if institution. Residence before admission) STATE Maryland COUNTY Seo.				13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 6500 Shadyside Ave							
14. FATHER'S NAME First Middle Last Joseph Chambers				15. MOTHER'S MAIDEN NAME First Middle Last Mary A. Ward			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Address George L. Mortimer, Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 5700 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Asystole DUE TO, OR AS A CONSEQUENCE OF Chronic Pyelonephritis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Generalized Atherosclerosis & Left Hemiparesis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/4/68 to 6/11/68 , that (I) (we) last saw the deceased alive on 6/11/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kelvin L. Minchin				22c. DATE SIGNED 6/11/68		22d. PHYSICIAN'S NAME (Type) KELVIN L. MINCHIN	
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6-14-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. SE., Suitland, Maryland				25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 7a & 7b, film G#01 6/10/68									
1. DECEASED NAME (Type or print) Michael F. Murphy						2a. DATE OF DEATH Month June Day 1 Year 1968		2b. HOUR 6.3 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11 June 1903		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Freight Agent		12b. KIND OF BUSINESS OR INDUSTRY E&O RR			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Cottage City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3717 Cottage Ter.	
14. FATHER'S NAME First Middle Last Michael F. Murphy				15. MOTHER'S M A D E N NAME First Middle Last Mary L. Curry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 719-01-0721		17. INFORMANT Address Mrs. Martha A. Murphy (above address)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Pulmonary Thrombo-Emboli 420 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pre-existent Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 432 X									
19a. DATE OF OPERATION 5-28-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHOLECYSTITIS CHLITHIASIS		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-25 , 1968, to 6-1 , 1968, that (I) (we) last saw the deceased alive on 6-1 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William B. Hogan M.D.				22c. DATE SIGNED 6-2-68		22d. PHYSICIAN'S NAME (Type) William B. Hogan M.D.			
23a. B. URIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/5/68		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				25a. REC'D BY REGISTRAR Charles J. J...		25b. REGISTRAR'S SIGNATURE Charles J. J...		DATE JUN 4 1968	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12-24-68 mt
Items 21c & 22a film 403 6-7-68
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 6-7-68			2b. HOUR 19 7:45pm
Pedro			Nadonga						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 6 Day 7 Year 68	2d. HOUR 19 8:01pm
Male	White	12 Jan. 1961	4 YRS						
7a. BIRTHPLACE (State or foreign country) Spain		7b. CITIZEN OF WHAT COUNTRY? Philipine Isles.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			MD
10. CITY OR TOWN OF DEATH Suitland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Andrews Air Force Base Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before address on) STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3118 Parkway Terrace Drive.
14. FATHER'S NAME Ricardo G. Nadonga			First	Middle	Last	15. MOTHER'S MAIDEN NAME EUFEMIA M. NADONGA			First Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO (If yes give war or dates of service) None		17. INFORMANT (Father) Ricardo G. Nadonga, Same as #13			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of gastric contents DUE TO, OR AS A CONSEQUENCE OF Associated with subdural hematoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Skull fracture DUE TO, OR AS A CONSEQUENCE OF and Multiple burns (c) and Multiple bruises									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6-4 P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Under investigation Unknown				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.) Home		21f. LOCATION Street or R.F.D. No 3118 Parkway Terrace		City or Town Suitland		County PG	State Md
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 6-9-68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6-11-68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. SE, Suitland, Maryland					25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Mary		First Mary		Middle Nealon		Last Nealon		2a. DATE OF DEATH Month June Day 24 Year 1968		2b. HOUR 3:30 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug 12 1876		6. AGE (In years last birthday) 91 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. (COUNTY OF) DEATH Prince George Md					
10. CITY OR TOWN OF DEATH Hyattsville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Chevy Chase		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2719 Blaine Drive	
14. FATHER'S NAME First Michael Middle Nealon Last Nealon				15. MOTHER'S MAIDEN NAME First Mary Middle Mullin Last Mullin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)				16b. SOCIAL SECURITY NO 221-20-8653		17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO, OR AS A CONSEQUENCE OF (c) None										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive Heart Failure											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year None		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) None							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.) None		21f. LOCATION Street or R.F.D. No. City or Town County State None							
22a. I certify that (I) (this hospital) attended the deceased from January 1959 , to June 24, 1968 , that (I) (we) last saw the deceased alive on June 22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James M. Loftus M.D.				22c. DATE SIGNED JUNE 24, 1968							
22d. PHYSICIAN'S NAME (Type) James M. Loftus M.D.				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/27/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION (City or Town) (County) (State) Wash. D.C.					
24. FUNERAL DIRECTOR Robert A. Pumpphrey				25a. REC'D BY REGISTRAR 7557 Wisc. Ave. Bethesda, Md.				25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

1. DECEASED NAME (Type or Print) Bernard Thomas Owens			2a. DATE KNOWN OF DEATH Month Day Year 19			2b. HOUR M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8-17-1903	6. AGE (in years last birthday) 64 YRS	7. IF UNDER 1 YEAR MONTHS DAYS	8. F UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 6 14 68 19 12:00 AM		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chamber's Funeral Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Railroad		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission), STATE Virginia		13b. COUNTY Alexandria		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 328 N. Columbus Street		
14. FATHER'S NAME First Middle Last Warren D. Owens			15. MOTHER'S MAIDEN NAME First Middle Last Mary Susan Pomeroy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. No		17. INFORMANT ADDRESS Mrs Nellie Hicks (sister)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF <u>And Subdural hematoma</u> (b) <u>Skull Fracture</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>last</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>9:00</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. unknown 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) unknown				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) unknown		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>								
ACTUAL SIGNATURE <u>John Kehoe MD</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 6-15-68		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 19, 1968		23c. NAME OF CEMETERY OR CREMATORY Round Hill		23d. LOCATION (City or Town) (County) (State) Ninde, King George Co., Va.		
24. FUNERAL DIRECTOR Nash & Slaw, Ninde, Va. 22526				25a. REC'D BY REGISTRAR DATE JUN 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) FRANK First PARACHINI Middle PARACHINI Last			2a. DATE OF DEATH 6 Month 27 Day 68 Year		2b. HOUR 10 45 AM
3. SEX MALE	4. RACE WHITE		5. DATE OF BIRTH 11/14/1881		6. AGE (In years last birthday) 87 YRS.
7a. BIRTHPLACE (State or foreign country) ITALY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH PRINCE GEORGE'S COUNTY Md					
10. CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HYATTSVILLE NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CEMENT MASON	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 701 WOODSIDE PARKWAY			
14. FATHER'S NAME First DOMINIC Middle PARACHINI Last PARACHINI			15. MOTHER'S MAIDEN NAME First AMELIA Middle LUCIA Last LUCIA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 066-01-2302		17. INFORMANT LAWRENCE PARACHINI Address SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral arteriosclerosis + decomposition 7-11-7 DUE TO, OR AS A CONSEQUENCE OF (b) moderate anemia - cause? BLEEDING DUE TO, OR AS A CONSEQUENCE OF (c) Possible malignancy abdomen Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS 4-5 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2044					
19a. DATE OF OPERATION 2044		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from MAY 12, 1965 , to 6/27, 1968 , that (I) (we) last saw the deceased alive on 6/27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE James A. Roberts		M.D. DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/27/68	
22d. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		22e. ADDRESS 8907 GEO. AVE. SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-29-68		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY	
23d. LOCATION (City or Town) N. ARLINGTON		(County) N.J.		(State) N.J.	
24. FUNERAL DIRECTOR Francis J. Collins		ADDRESS 3821-14th St NW		25a. RECD BY REGISTRAR DATE JUL - 1 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) EMIL FRANKLIN PASCHAL			2a. DATE OF DEATH Month JUNE Day 6 Year 1968			2b. HOUR 7 P.M.			
3 SEX M		4 RACE W		5. DATE OF BIRTH APRIL 19 1913		6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) N. CAROLINA		7b. CIT ZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGE Md.			
10. CITY OR TOWN OF DEATH RIVERDALE		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) EUGENE LELAND MEMORIAL HOSP		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) POINT UP MAN		12b KIND OF BUSINESS OR INDUSTRY CONSTRUCTION			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE M.D.		13b. COUNTY P.G.		13c CITY OR TOWN LAUREL		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 209 9th ST.	
14. FATHER'S NAME First Middle Last EMIL F. PASCHAL			15. MOTHER'S MAIDEN NAME First Middle Last CADIE ALINE PIKE						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO 578-07-0019		17 INFORMANT Address MRS. JULIE KNISLEY - ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis TOIX DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) High Blood pressure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1d 24 hours									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) XXXX									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from NOV. 15, 1966 to MAY 11, 1968 , that (I) (we) last saw the deceased alive on MAY 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert S. McCeney				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/10/68			
22d. PHYSICIAN'S NAME (Type) Robert S. McCeney, MD				22e. ADDRESS 402 Main St., Laurel, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-10-68		23c. NAME OF CEMETERY OR CREMATORY Charles Hill Cem		23d. LOCATION (City or Town) (County) (State) Sutland Md			
24. FUNERAL DIRECTOR De Witt Connelley, Laurel Md				25a. REC'D BY REGISTRAR DATE JUN 12 1968		25b. REGISTRAR'S SIGNATURE William J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Anne Z. Peek			2a. DATE OF DEATH 6 Month 9 Day 68 Year			2b. HOUR 1:30 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/24/96		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) Greenland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if instit. on. Res. dence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIM 1ST NO		13e. STREET AND NUMBER 4317 40th Place	
14. FATHER'S NAME First Middle Last John Zebley			15. MOTHER'S MA 'EN NAME First Middle Last Sara Jane Hall						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address William F. Peek Sr. Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4127 VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last GEN ARTERIOSCLEROSIS (b) UNKNOWN (c) UNKNOWN								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-28 , 19 68 , to 9 JUNE , 19 68 , that (I) (we) last saw the deceased alive on 9 JUNE , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C.J. HODMANN				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10 JUNE 68			
22d. PHYSICIAN'S NAME (Type) C.J. HODMANN MD				22e. ADDRESS RIVERDALE MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/12/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...			

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b HOUR		
Alfred S Pence						6-19-68 192			4:00pm		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Male	White	8-14-1922	45 YRS					6 19 68 192			4:00pm M.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.		
Va.		U. S. A.				Prince George's					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Riverdale			Leland Memorial Hospital								
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's			Seabrook			9609 Woodbury Street		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Albert S. Pence			Treva R. Summers								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO (If no, give last or date of service)			17 INFORMANT ADDRESS					
Yes			WW 11			Ruth A. Pence Same as # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral hemothorax 823.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:40pm 6-19- 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Chest crushed between truck and trailer			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Giant Food Warehouse garage, Sheriff Rd., Landover, Maryland				21f. LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				6-20-68			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORIUM			23d LOCATION (City or Town) (County) (State)		
Burial			6/22/68			Bethel Church of The Brethren			Broadway, Va.		
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
F. Gasch's Sons 4739 Balt. Ave., Hyattsville, Md.						JUN 25 1968			John A. Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-1. 5 may be retained for your files.

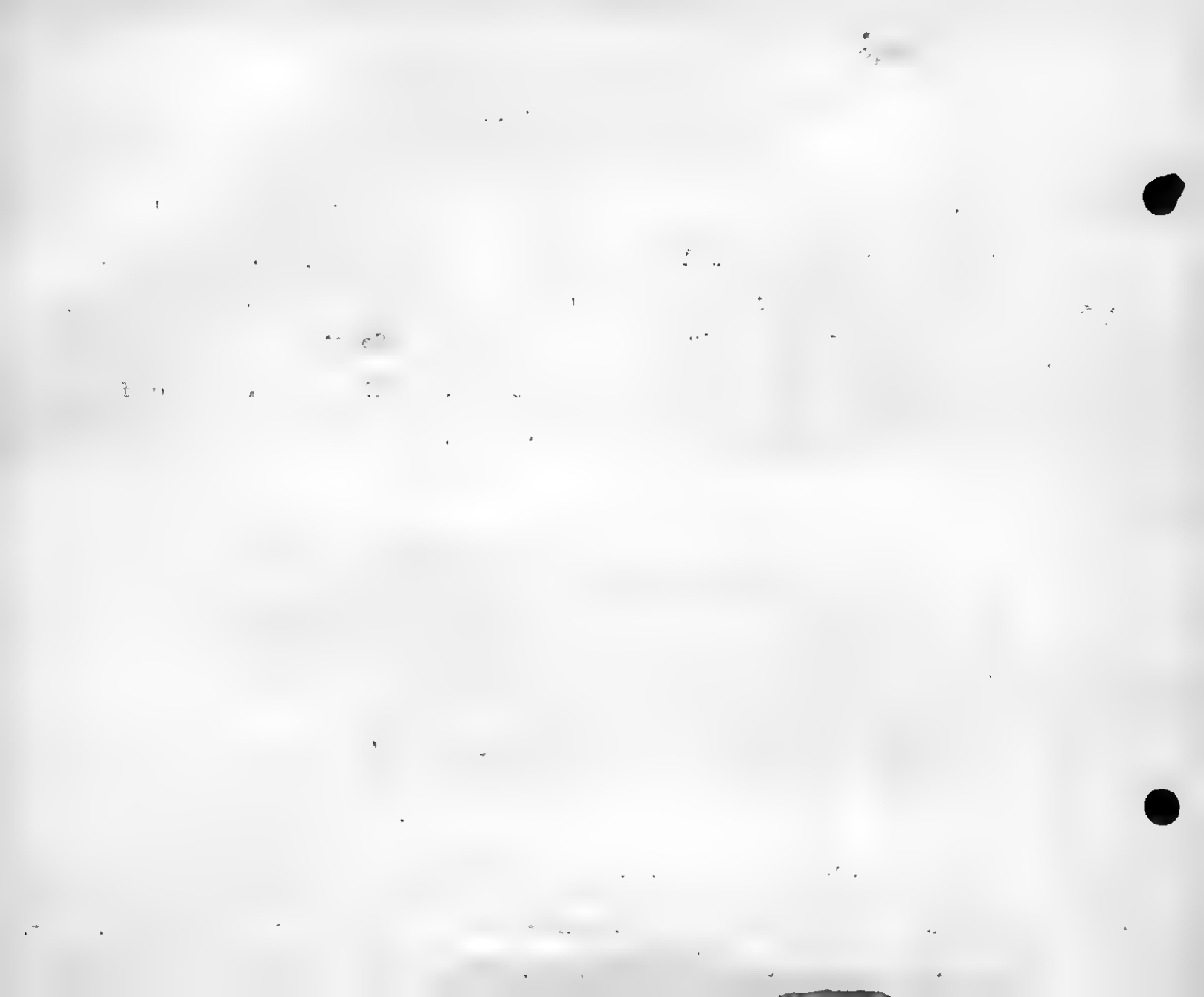
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Woodrow W. Perrie			2a. DATE OF DEATH Month Day Year 6 10 68			2b. HOUR 6:40pm					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10/30/18		6. AGE (in years last birthday) 49 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Riverdale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Landscapeing			12b. KIND OF BUSINESS OR INDUSTRY nursery		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Hyatts			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 4218 Kennedy Street			14. FATHER'S NAME First Middle Last Thomas Perrie			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Windson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. (If yes give year or dates of service)			17. INFORMANT Rose M. Perrie Same as #13 (wife)			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4270 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE MONTH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4341											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2 JUNE, 1968, to 10 JUNE, 1968, that (I) (we) last saw the deceased alive on 10 JUNE 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. J. Houmann			DEGREE C. J. Houmann, M. D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 11 JUNE 68		
22d. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D.			22e. ADDRESS Riverdale, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6/13/68			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE JUN 14 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Samuel A. Perzella			2a. DATE OF DEATH Month 6 Day 11 Year 68			2b. HOUR 9:20 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 24, 1886		6. AGE (In years last birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) Hawley, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Magnolia Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret Plant Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Textile	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md		13b. COUNTY P.M.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Joseph Middle Parzella Last Anna		15. MOTHER'S MAIDEN NAME First Anna Middle M Last Perazzo					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 185 10 8079		17. INFORMANT William Murphy Address Bowie, Maryland			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC COR PULMONALE DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE EMPHYSEMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 5 YEARS 15 YEARS
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from DEC. 1967 , to 11 JUNE 1968 , that (I) (was) last saw the deceased alive on 8 JUNE 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death							
22b. SIGNATURE John Cosma M.D. DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) JOHN COSMA, M.D.						22e. ADDRESS 3233 SUPERIOR, BOWIE, MD.	

23a. BURIAL CREMATION, REMAINS (Specify) Burial		23b. DATE 6/14/68		23c. NAME OF CEMETERY OR CREMATORY Mother of Sorrows		23d. LOCATION (City or Town) (County) (State) Finch Hill Lackawanna Pa.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JUN 14 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



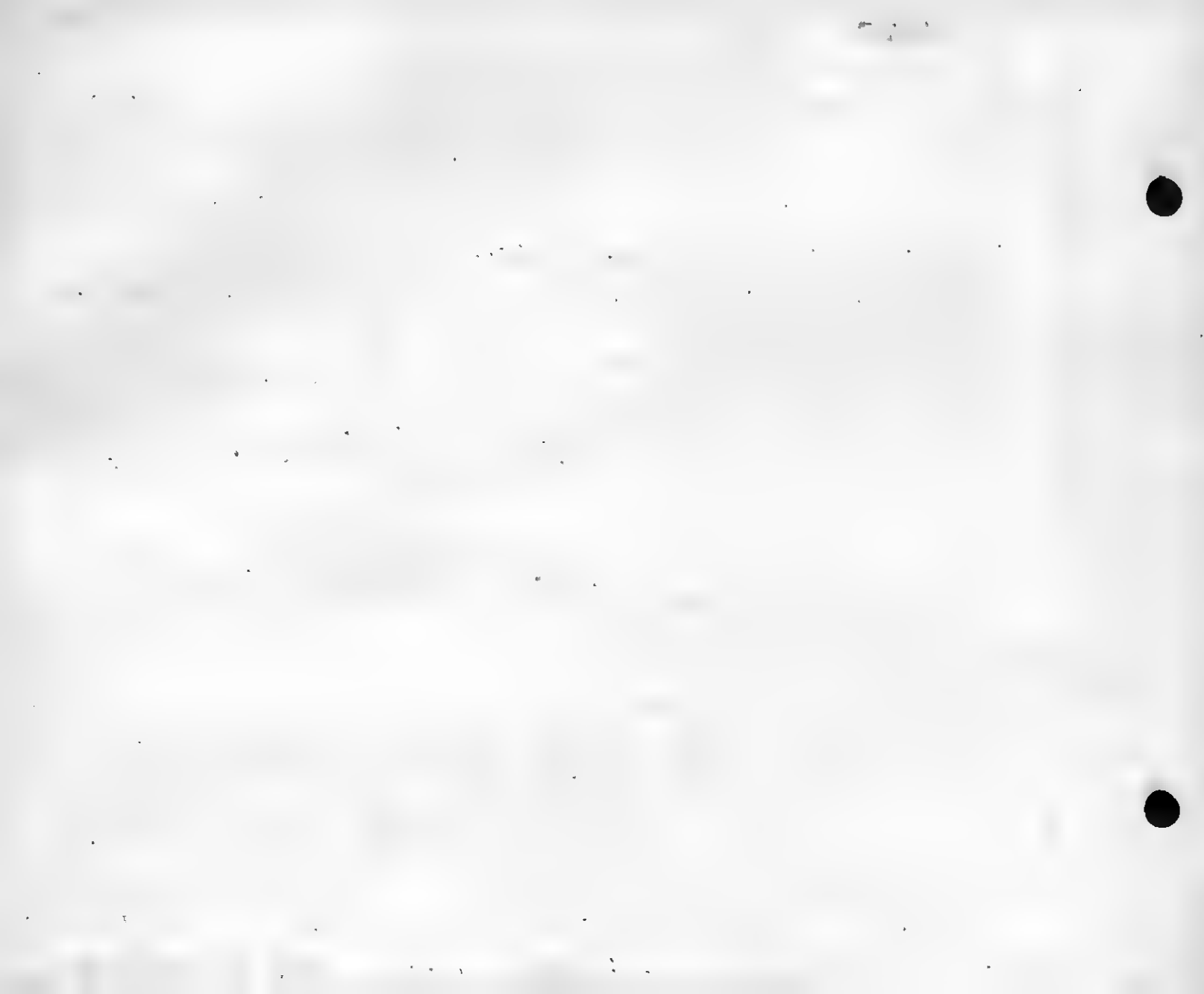
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Hazel Pryor			2a. DATE OF DEATH Month Day Year June 30th 1968			2b. HOUR AM PM 12:20 AM			
3. SEX F		4. RACE Negro		5. DATE OF BIRTH 9/7/11		6. AGE (In years last birthday) 56 YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges County Md.			
10. CITY OR TOWN OF DEATH Hyattsville Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hosp.,		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) cook		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Brentwood Md.		13b. COUNTY Prince Georges		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4506 Rhode Island Ave.,	
14. FATHER'S NAME First Middle Last William Henry Austin			15. MOTHER'S MAIDEN NAME First Middle Last Lizzie L Lambert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Edith Allen		Address Northfork, West Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinomatosis 1771 DUE TO, OR AS A CONSEQUENCE OF primary source undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension and Congestive Ht. Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 19, 1968 , to June 29, 1968 , that (I) (we) last saw the deceased alive on June 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L W Malin		DEGREE L W MALIN MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/30/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/14/68		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Bluewell, West Virginia			
24. FUNERAL DIRECTOR John H. Stewart		25a. REC'D BY REGISTRAR Full - 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #24,23c, Film 410 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b HOUR	
Kay			M.			Ramm		June 27, 1968 8:20 A	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
Female	Cauc.	Unknown	58 YRS			June 27, 1968		8:20 A	
7a BIRTHPLACE (State or foreign country)	7b C I ZEN OR WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
USA	USA				Prince George's Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Georges General Hospital			Retired		Z	
13a USUAL RESIDENCE (Where deceased lived, if institution Res before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY & MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md			Pr Geo Hyattsville					5706 - 4200	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Unknown									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
Unknown						Prince Georges Police			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cordine De compensat 1 hr									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions if any, which gave rise to immediate cause (a) stating the underlying cause lost									
(b) Cor pulmonale - Emphysema years									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Chronic Bronchitis									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
			19						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b DATE SIGNED 6-28-68			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5318 Annapolis Rd						
22c ADDRESS (Street, city, town, or county)			Blacksburg Md						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
					Anatomy Board				
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
Anatomical Board, Balto. Md. VIA 5601 Cleveland			JUL - 9 1968			J Charles Janga			
W.W. Chambers Funeral Home, Riverdale, Md.									



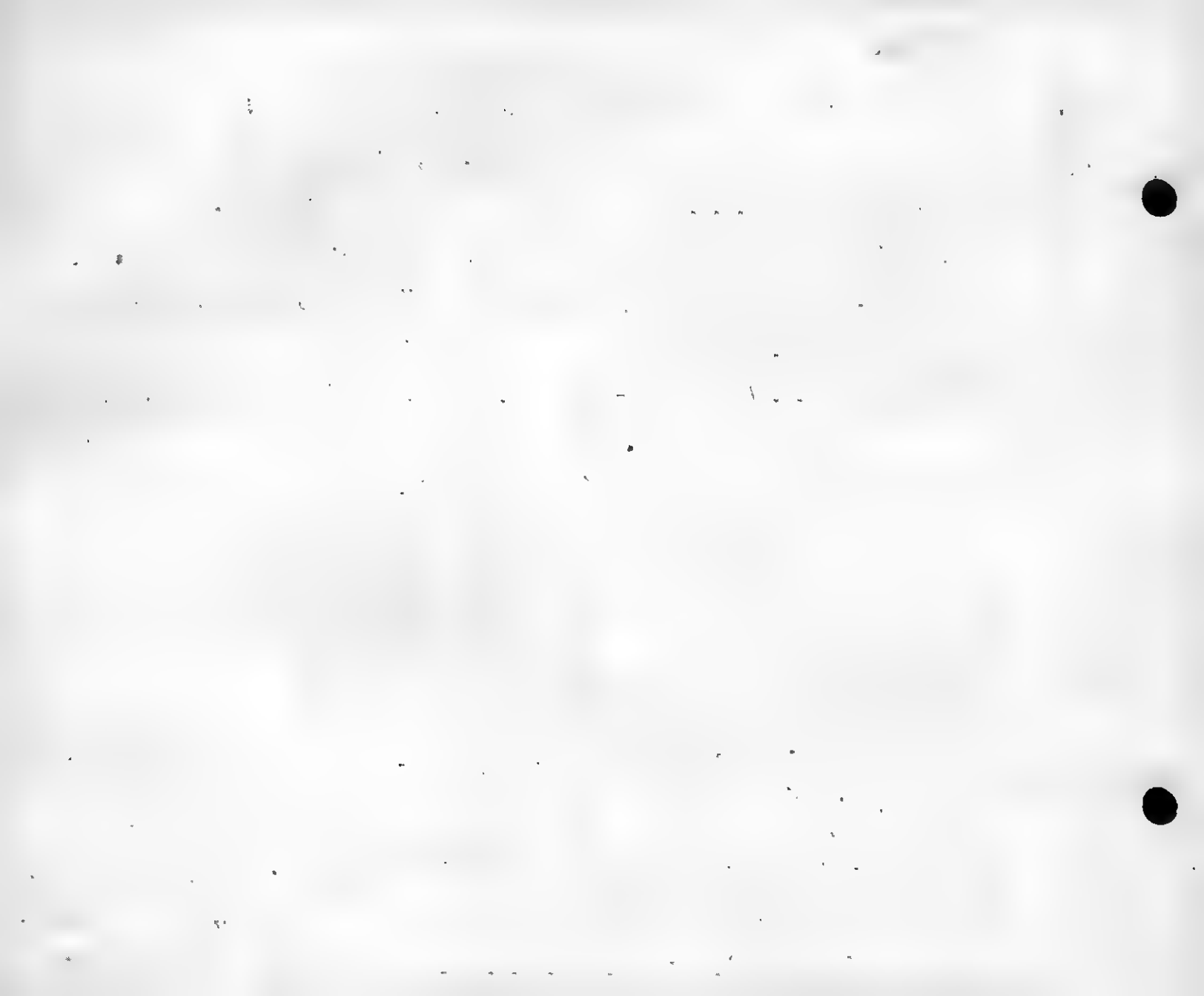
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 105 (1)
304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

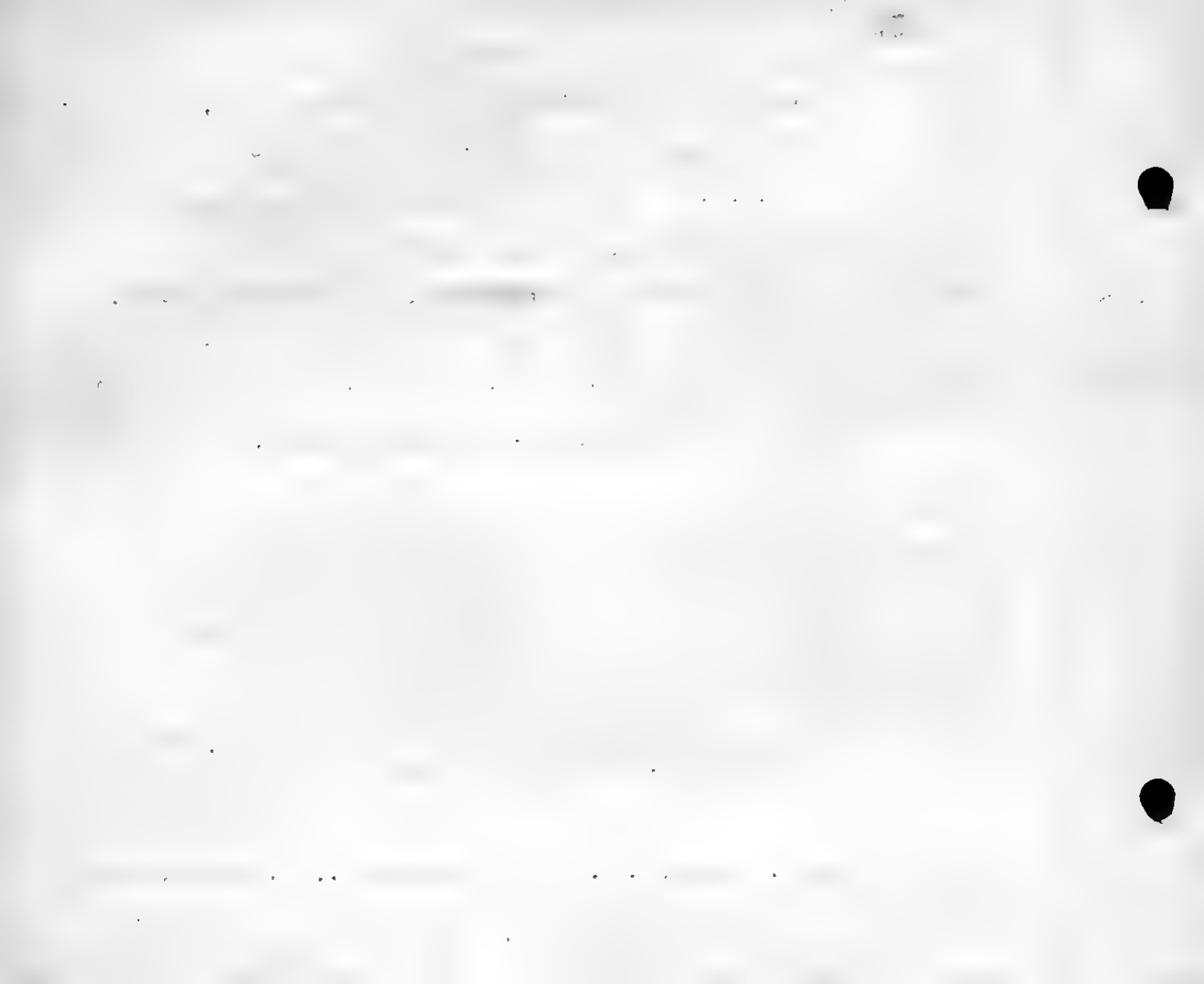
1. DECEASED-NAME (Type or print) <i>Arthur Irvin Rhodenbaugh</i>			2a. DATE OF DEATH Month <i>E</i> Day <i>18</i> Year <i>68</i>		2b. HOUR <i>10:15 PM</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Jan. 28, 1891</i>		6. AGE (In years last birthday) <i>77</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Illinois</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince George</i> Md.		
10. CITY OR TOWN OF DEATH <i>Adelphi</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hill Haven Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <i>Machinist</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Prince George</i>	13c. CITY OR TOWN <i>Adelphi</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>10526 Deakins Hill Road</i>	
14. FATHER'S NAME First Middle Last <i>Benjamin J. Rhodenbaugh</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Ella Valentine</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give year or dates of service) <i>W.W.I.</i>		16b. SOCIAL SECURITY NO. <i>707-16-4204</i>	17. INFORMANT Address <i>Mr. Lawrence Rhodenbaugh 10526 Deakins Hill</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>47 yr. X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ess. advanced pulmonary emphysema</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 yrs.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>521</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 19 <i>68</i> , to <i>6-18</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6-18</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R.D. Baner, MD</i>	DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>6-18-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>R.D. Baner, MD</i>	22e. ADDRESS <i>2513 Buck Lodge Rd. Adelphi, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>June 22, 1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince George Maryland</i>		
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey Inc. 8434 Gt. Ave. S.S., Md.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <i>JUN 25 1968</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

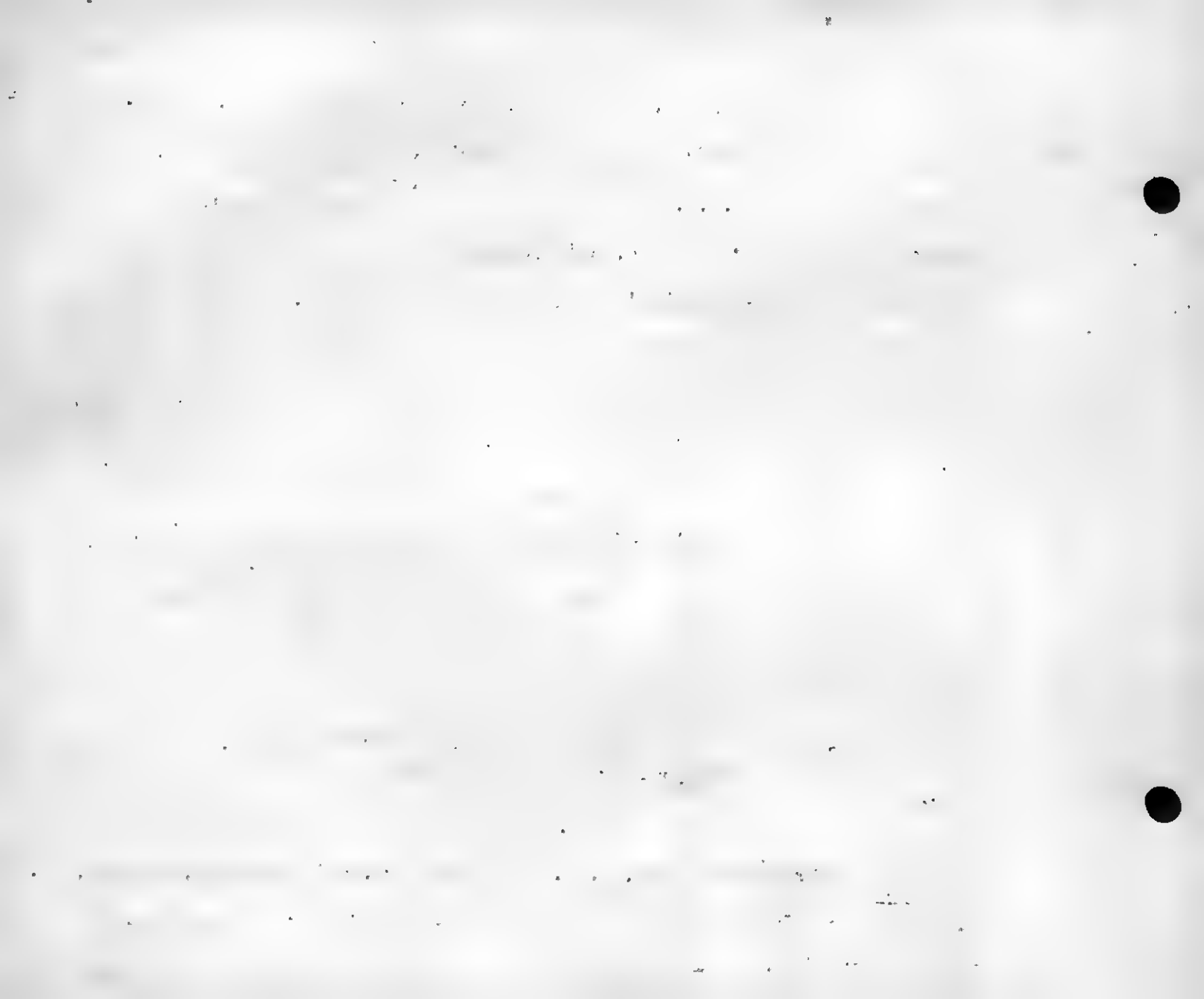
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH		DOA HOUR			
First Middle Last Robert W. Rickey					June Month 10, Day 1968 Year		4:30A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
Male		Caucasian		Nov. 14, 1919		48 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Ohio		U. S. A.				Prince Georges Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			DOA @ Prince George's Gen'l Hospital			Manager		Drug Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George's		Suitland				5103 Logan Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
John A. Rickey			Nettie W. Kinder							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
			280 18 1368		Rev. Norman V. Rickey Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Thrombosis - left coronary artery.</u> 4107 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (the doctor) attended the deceased from April, 1968 to June 10, 1968, that (I) (we) last saw the deceased alive on June 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Don B. Cameron</u> DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED June 10, 1968			
22d. PHYSICIAN'S NAME (Type) Don B. Cameron, M. D.					22e. ADDRESS 3503 Perry St., Mt. Rainier, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)		20822		
Burial		6/12/68		Ft. Lincoln		Colmar Manor P.G.		Md.		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.					Jun 17 1968		<u>Francis Gasch</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

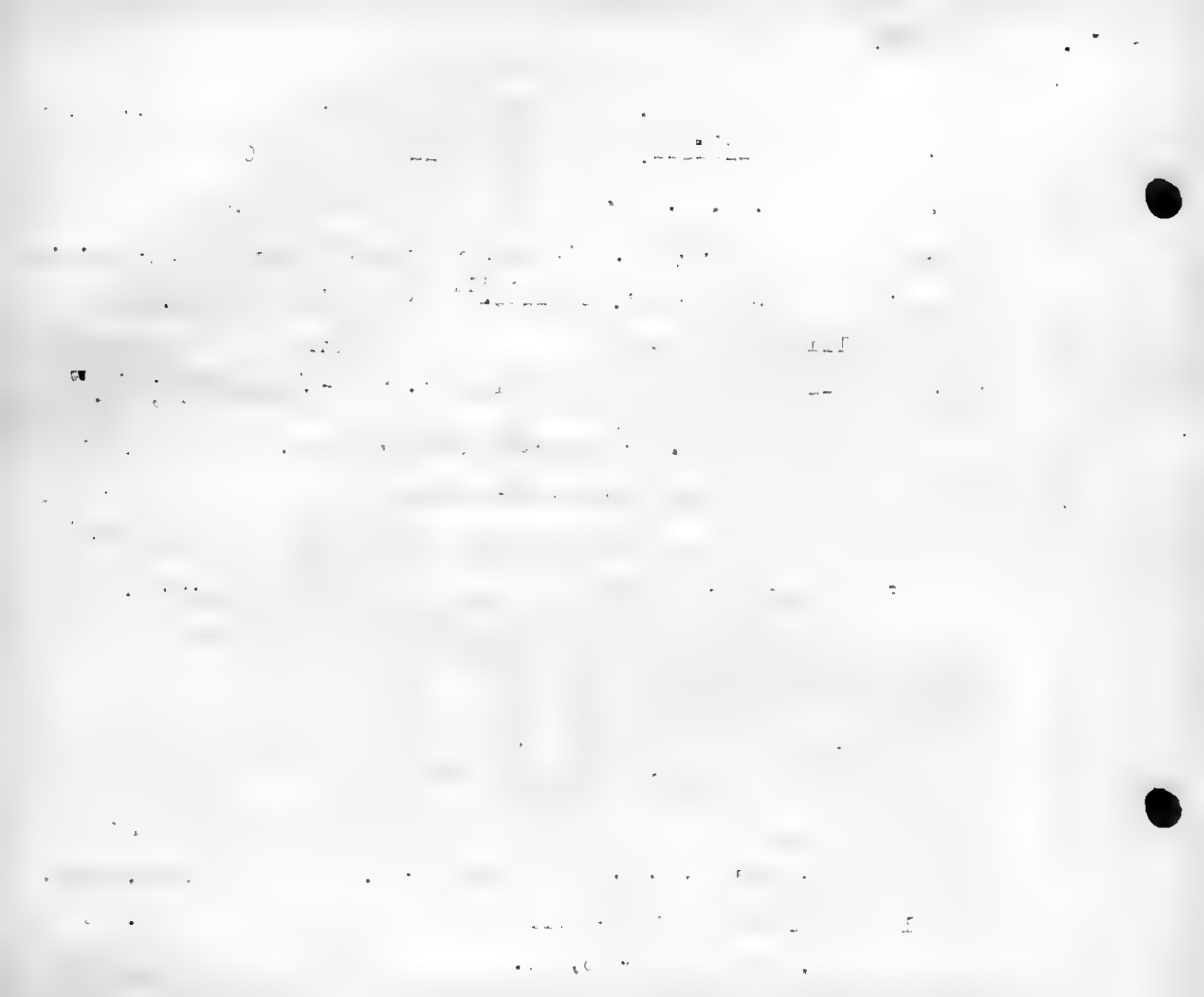
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #15 Taken from birth certif. CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR A M
Baby Boy Robinson						June 6, 1968			10:15
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS
Male		Negro		June 5, 1968			YRS /		30 23
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Prince George's Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince Geo. Gen'l Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Prince George's		Brandywine		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. Box 116
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
			Elizabeth Lorraine Robinson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immaturity, 800 GMS.</u> <u>1762</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atelectasis neonatorum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>respiratory distress syndrome</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 5, 1968</u> to <u>June 6, 1968</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 6, 1968</u> , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
								6/7/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Bernardo Alvarado, M. D.				Prince Geo. Gen'l Hospital, Cheverly, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		6/29/68		Prince Geo. General Hospital		Cheverly, Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
WILLIAM A. PARKER, ASSOC. ADMINISTRATOR				JUL - 2 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
George C. Ross						June 28, 1968			10:20 A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER YEAR	
Male		White Caucasian		7/23/32		70 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Canada		U. S. A.				Prince George's Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince Geo.Gen'l Hospital				Exterminator		U.S. Government	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Prince George's		Forestville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8428 Leona St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
William Ross						Minnie Aainsworth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
Unknown						Nellie W. Ross-8428 Leona Street Forestville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Bilateral confluent bronchopneumonia.</u>									1 week
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Recent cerebral infarction, left</u>									24 hrs
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Generalized arteriosclerosis - severe</u>									unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>Stenosing coronary artery disease with old myocardial infarction.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (this hospital) attended the deceased from <u>June 4,</u> 19 <u>68</u> , to <u>June 28,</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June 28,</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<u>Leon Levitsky, M. D.</u>						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		6/28/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Leon Levitsky, M. D.						Prince Geo.Gen'l Hospital, Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		7/2/68		Cedar Hill Cemetery		Suitland		Pr. Geo Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ritchie Bros. Upper Marlboro, Md.						JUL - 3 1968		<u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caption paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
3041 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) BERT First ELMER Middle SAGER Last			2a. DATE OF DEATH 6/1/68 Month 6 Day 1 Year 68		2b. HOUR 11:00 M PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH Feb. 1, 1895		6. AGE (In years lost birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George Md.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Magnolia Gardens N.H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret Attorney at Law	12b. KIND OF BUSINESS OR INDUSTRY Self	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Prince George	13c. CITY OR TOWN Adelphi	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2110 Rolander Street	
14. FATHER'S NAME First Amos Middle Sager Last Sager		15. MOTHER'S MAIDEN NAME First Eliza Middle See Last See			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578 46 6341A	17. INFORMANT Address Martha L. Sager Same as #13 (wife)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436.0 DUE TO, OR AS A CONSEQUENCE OF C.V.A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Art Sclerosis (Cardiac) (b) Essential Hypertension DUE TO, OR AS A CONSEQUENCE OF Essential Hypertension (c) Essential Hypertension					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 3.3.1.4					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 1 Day 1 Year 68 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 1, 1968 , to June 1, 1968 , that (I) (we) lost saw the deceased alive on June 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William R. Greco, M.D.		22c. DATE SIGNED 6/1/68		22d. ADDRESS 6201 Riverdale Rd. Riverdale, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 6/4/68	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR JUN 10 1968		25b. REGISTER SIGNATURE Francis Gasch

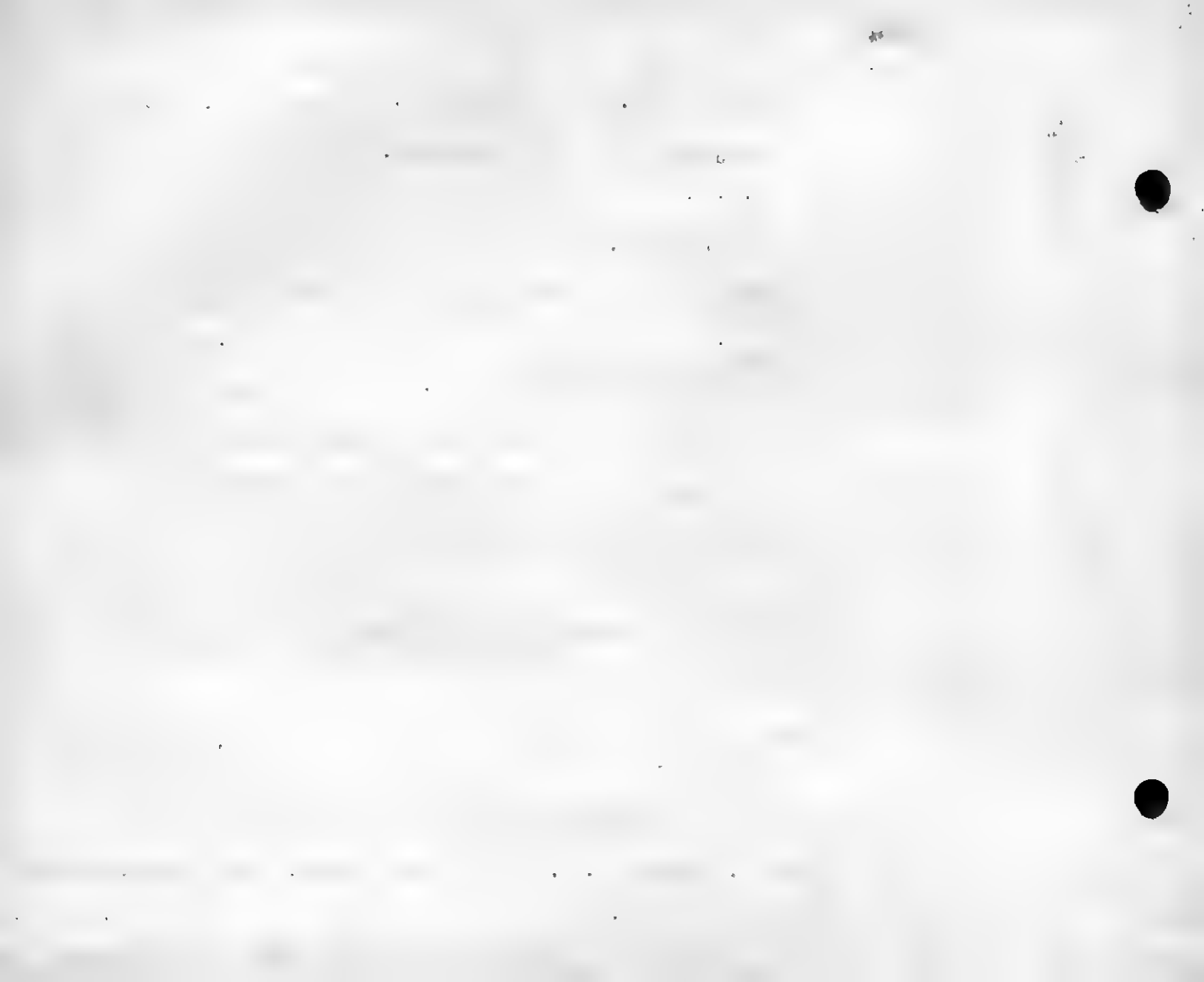
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-1-68
30M RPL-1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) William H. Sandrus Sr.			2a. DATE OF DEATH Month June , Day 20 , Year 1968			2b. HOUR 11:15 P				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH August 11, 1915		6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 MRS. HOURS		
7a. BIRTHPLACE (State or foreign) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Colmar Manor			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First William Middle H. Last Sandrus			15. MOTHER'S MAIDEN NAME First Gertrude Middle E. Last Walls			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give branch or dates of service) Yes WW 11				
16b. SOCIAL SECURITY NO. 577 16 1845			17. INFORMANT Address Evelyn L. Sandrus Same as #13 (wife)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto CVA left car of id destruction DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cardiac vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 475 X										
19a. DATE OF OPERATION 475 X			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholelithiasis and cyst of gall of pancreas			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County
22a. I certify that (I) George J. Hageage attended the deceased from MAY 1 , 19 63 , to June 20 , 19 68 , that (I) (was) last saw the deceased alive on June 20 , 19 68 , and that in (my) home opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (not) view the body after death.										
22b. SIGNATURE George J. Hageage			DEGREE M. D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/21/68		
22d. PHYSICIAN'S NAME (Type) George J. Hageage, M. D.			22e. ADDRESS 3717 38th Avenue, Cottage City, Maryland							
23a. BURIAL, CREMATION, or other disposition Burial			23b. DATE 6/24/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland						25a. REC'D BY REGISTRAR DATE JUN 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Charles F. Schipula			2a. DATE OF DEATH Month June , Day 6 , Year 1968		2b. HOUR 11:05 AM
3 SEX Male	4. RACE Caucasian	5. DATE OF BIRTH June 14, 1902		6 AGE (In years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Texas	7b. CITIZEN OF WHAT COUNTRY? U S A	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.		
10 CITY OR TOWN OF DEATH Cheverly	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Contractor	12b KIND OF BUSINESS OR INDUSTRY Self	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2603 Kresson Place	
14 FATHER'S NAME First Joseph Middle ---- Last Schipula		15 MOTHER'S MAIDEN NAME First Rosa Middle ---- Last Bubela			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, aa, or unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO 454 18 3309A		17. INFORMANT Address Jenny Schipula Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1621 (b) Circumference of bronchus DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Alterschistic heart disease. Cerebral arteriosclerosis					
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the deceased) attended the deceased from 5-21 , 19 68 , to June 6 , 19 68 , that (I) (the) last saw the deceased alive on June 6 , 19 68 , and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above, (I) (the) (did) (deceased) view the body after death.					
22b. SIGNATURE Fidel J. Quintana		DEGREE XXX	ATTENDING PHYS. XXX	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) Fidel J. Quintana, M. D.		22e ADDRESS 12004 Maycheck Lane, Bowie, Md. 20715		22c. DATE SIGNED 6-6-68	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE June 10 1968	23c NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	23d LOCATION (City or Town) Washington, D.C.	(County) (State)	
24 FUNERAL DIRECTOR Nalley Funeral Home Mt. Rainier, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE JUN 10 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Jennie Mae Schrum			2a. DATE OF DEATH Month Day Year June 9 1968			2b. HOUR 8:30 AM			
3 SEX F		4 RACE W		5. DATE OF BIRTH 4-14-1877		6 AGE (n years last birthday) 91		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Williamsport Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE md.		13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2000 Beechwood Rd.	
14. FATHER'S NAME First Middle Last Leightner Ellis Reed		15. MOTHER'S M maiden name First Middle Last Homeretta Reed							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (1 yes give war or dates of service)		16b. SOCIAL SECURITY NO 577-01-20130		17. INFORMANT Jennie A. Schrum		Address 2000 Beechwood Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory failure 412.1 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Unknown cause Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 12 hrs. 30+ years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) dehydration & malnutrition									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 6, 1968 , to June 3, 1968 , that (I) (we) last saw the deceased alive on June 3, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE Robert D. McCormick MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/9/68			
22d. PHYSICIAN'S NAME (Type) R.A. McCormick		22e. ADDRESS 1161 New Hampshire Ave. S.W. Wash DC							
23a. BURIAL, CREMATION, REMOVAL (Specify) June 12-1968		23b. DATE June 12-1968		23c. NAME OF CEMETERY OR CREMATORY St. Lawrence		23d. LOCATION (City or Town) (County) (State) Beltsville Md. Prince Georges			
24. FUNERAL DIRECTOR Charles Judge		ADDRESS 754 Connel St NW		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

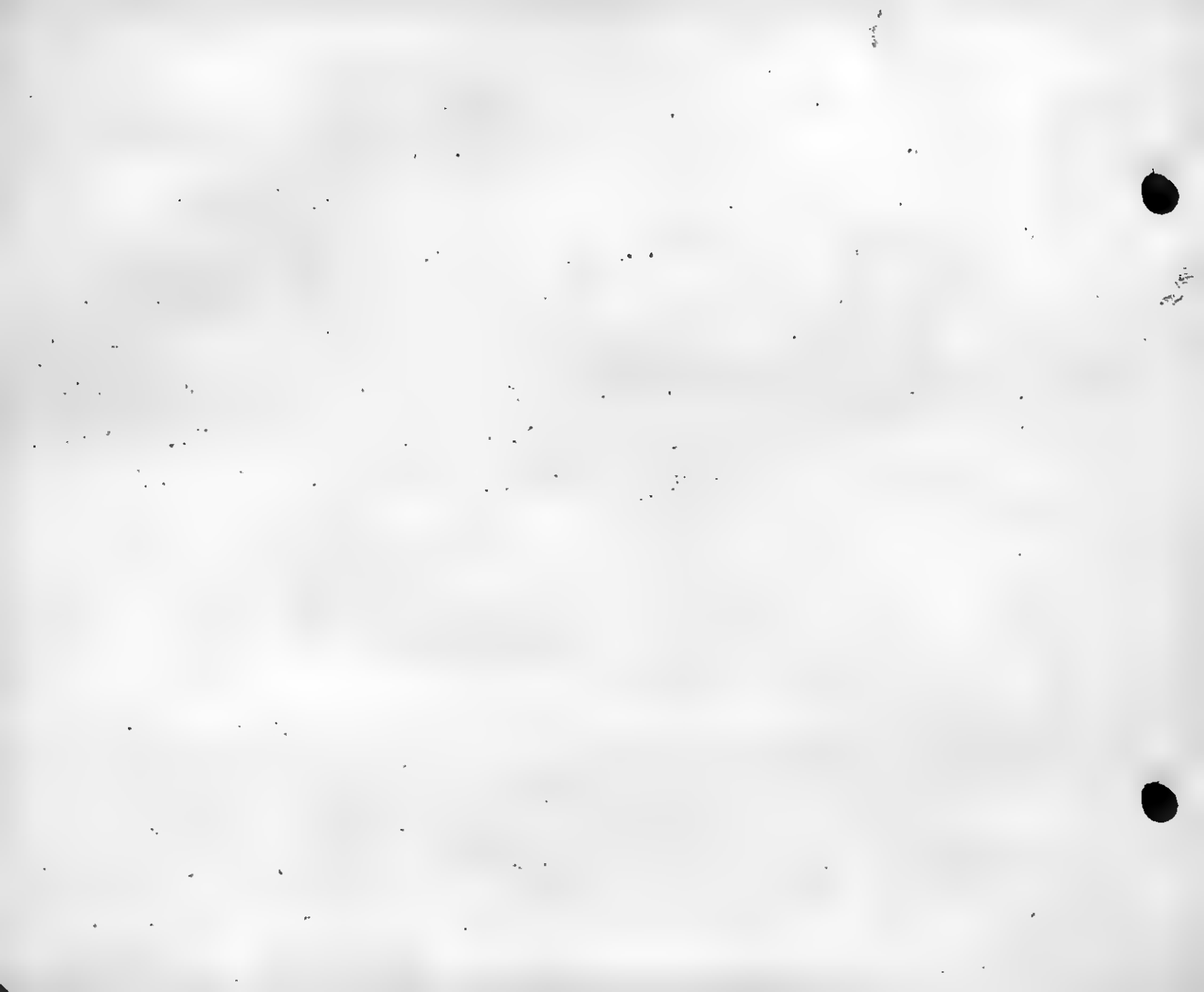
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Released by Medical Examiner Dr. Ke Hoé 15K

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

55962

1. DECEASED NAME (Type or print) First Middle Last ABE D. SCHWARTZ			2a. DATE OF DEATH Month Day Year 6 20 1968		2b. HOUR 10 05 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH Dec. 7, 1908		6. AGE (in years last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges Md		
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.	13b. COUNTY Bladensburg	13c. CITY OR TOWN Bladensburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5800 Annapolis Rd.	
14. FATHER'S NAME First Middle Last Joseph Schwartz		15. MOTHER'S MAIDEN NAME First Middle Last Bertha Freedman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO. 187-03-1711	17. INFORMANT Miss Sara Schwartz Address Southampton Co Bl.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 3 hrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/23 , 19 68 , to 6/20 , 19 68 , that (I) (we) last saw the deceased alive on 3/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Julius Kauffman MD		22c. DATE SIGNED 6/24/68	22d. PHYSICIAN'S NAME (Type) JULIUS KAUFFMAN, MD		
22e. ADDRESS 6501 LANDOVER RD. - CHEVERLY, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/23/68	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Mem. pk	23d. LOCATION (City or Town) (County) (State) Hyattsville, Md.		
24. FUNERAL DIRECTOR B. Langley & Sons		24a. ADDRESS 3501-14th St NW	25a. REC'D BY REGISTRAR JUN 26 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Ernest L. Scott			2a. DATE OF DEATH Month Day Year June 26 1968			2b. HOUR 3:50 A.M.	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 3-18-1900		6. AGE (In years last birthday) 68 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Glenn Dale (rural)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unknown - retired		12b. KIND OF BUSINESS OR INDUSTRY Unknown	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1409 Half Street, S.W.		14. FATHER'S NAME First Middle Last Edward Scott		15. MOTHER'S MAIDEN NAME First Middle Last Hattie Yeager			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO ---		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of neck 1614 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1614x (b) Carcinoma of larynx with laryngectomy DUE TO, OR AS A CONSEQUENCE OF (c) 4 years							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary tuberculosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/22, 19 68, to 6/26, 19 68, that (X) (we) last saw the deceased alive on 6/26, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death							
22b. SIGNATURE Moe Weiss				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/26/1968	
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-29-1968		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Prince Georges Co. Md		23d. LOCATION (City or Town) (County) (State) 9th	
24. FUNERAL DIRECTOR Lalney Funeral Home Wash., D.C.				ADDRESS 38 31 3rd St. Wash., D.C.		25a. REC'D BY REGISTRAR DATE JUL - 1 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Ernest Joseph Seek			2a. DATE OF DEATH Month June Day 16 Year 1968			2b. HOUR 1.50AM								
3 SEX Male		4. RACE White		5. DATE OF BIRTH 1 Mar., 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo.								
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen., Hosp.,		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5707 Ager Road						
14. FATHER'S NAME First David Middle O. Last Seek		15. MOTHER'S MAIDEN NAME First Mary Middle C. Last Bradecamp												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown Yes		16b. SOCIAL SECURITY NO WW 1		17. INFORMANT Lillian E. Seek Same as #13 (wife)		Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arteriosclerotic disease HEART Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1950 to June 6, 1968 , that (I) (we) last saw the deceased alive on June 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE R. R. Fleischman DEGREE											ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6-16-68	
22d. PHYSICIAN'S NAME (Type) Dr. R. Fleischman M.D.											22e. ADDRESS			
23a. BURIAL, CREMATION, REBURY (Specify) Burial			23b. DATE 6/19/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.						
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.						ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 20 1968		25b. REGISTRAR'S SIGNATURE J. Charles Jones				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Frances Gertrude Severe			2a DATE OF DEATH Month June Day 19 Year 1968			2b HOUR 9 P M			
3. SEX F		4. RACE W		5 DATE OF BIRTH 1-30-23		6. AGE (In years last birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Scranton Pa.		7b. CITIZEN OF WHAT COUNTRY? U S		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			
10 CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2102 Vanduren St		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK		12b KIND OF BUSINESS OR INDUSTRY Department Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2102 VAN BUREN ST	
14. FATHER'S NAME First Middle Last MORRIS			15 MOTHER'S MAIDEN NAME First Middle Last NEUMAN			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			
16a. SOCIAL SECURITY NO			17 INFORMANT Harry Severe, 2102 Vanduren St			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Breast Adenocarcinoma 114X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 54 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 170X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept 1967 to 6/19/68 , that (I) (we) last saw the deceased alive on 6/18/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. Lennard Gold		22c. DATE SIGNED 6/19/68		22d. PHYSICIAN'S NAME (Type) G. LENNARD GOLD		22e. ADDRESS 4601 Georgia Avenue, Silver Spring MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/21/68		23c. NAME OF CEMETERY OR CREMATORY DALTON Jewish Cem.		23d. LOCATION (City or Town) (County) (State) DALTON PA.			
24. FUNERAL DIRECTOR B. DANZANSKY & SONS. 3501 14TH ST N.W. WASH. DC.				25a. REC'D BY REGISTRAR DATE JUN 24 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George County MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Forest Knolls</u> c. LENGTH OF STAY IN IT <u>5 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9525 Chalfont Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Forest Knolls, (Rural)</u> d. STREET ADDRESS <u>9525 Chalfont Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Lucille Katherine Shegogue</u>		4. DATE OF DEATH <u>June 27 1968</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 25, 1895</u>		9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>2</u> Hours <u>15</u> Min <u>0</u>		11. IF UNDER 24 HRS. Hours <u>15</u> Min <u>0</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>				11. BIRTHPLACE (County & State, or Foreign country) <u>Richmond, Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>James Scott</u>				14. MOTHER'S MAIDEN NAME <u>Unbrun</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>718-18-0173</u>				17. INFORMANT <u>Susie Bradhurst, 9525 Chalfont Ave</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca of Left Breast</u> 174x Conditions, if any, which gave rise to immediate cause (b) <u>174x</u> (c) <u>174x</u> cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e) <u>174x</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>October 6, 1965</u> to <u>6-27</u> , 1968 that (I) (we) last saw the deceased alive on <u>6-25</u> , 1968 and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.																							
22a. SIGNATURE <u>Anna Coyne Todd</u> M.D.				22b. DATE SIGNED <u>6/27/68</u>				22c. PHYSICIAN'S NAME (Type) <u>ANNA COYNE TODD</u>				22d. ADDRESS <u>1021 Broadview Rd D.C. 20022</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>June 29, 68</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Oxon Hill, Maryland.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Brodeur</u>				ADDRESS <u>1661-63 Hope Rd. SE.</u>				25a. REC'D BY REGISTRAR <u>Jul - 1 1968</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item #13a,b,c,e F-1117/6-102 7/2/68, 325P
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Barbara E. Sherbert			2a. DATE OF DEATH Month June Day 17 Year 1968			2b. HOUR 7 P. M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10/8/20		6. AGE (in years last birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. General Hosp.			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
3a. US. AL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER -----		
14. FATHER'S NAME First Harmer Middle Bobannon Last Bobannon			15. MOTHER'S MAIDEN NAME First unknown Middle ----- Last -----								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 579-12-7852		17. INFORMANT James A. Sherbert Sr. Upper Marlboro Md			Address Box 9005			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tubercular Construction DUE TO, OR AS A CONSEQUENCE OF (b) Intraabdominal metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma breast									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 9 months 3 yr		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X											
19a. DATE OF OPERATION 6/14/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intraabdominal Construction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 6/10 , 19 68 , to 6/17 , 19 68 , that (I) (we) last saw the deceased alive on 6/17 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE George S. Banning M.D.					22c. DATE SIGNED 6/18/68						
22d. PHYSICIAN'S NAME (Type) George S. Banning, M.D.					22e. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) 6/21/68		23b. DATE 21st		23c. NAME OF CEMETERY OR CREMATORY Shope Chapel			23d. LOCATION (City or Town) (County) (State) Edgewater A.A. Md				
24. FUNERAL DIRECTOR Hardisty Funeral Home Silverville Md					25a. REC'D BY REGISTRAR JUN 24 1968			25b. REGISTRAR'S SIGNATURE James Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 413 (7)
30M REV. 7-64

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) SH Bessie			First Middle Last S SHANK			2a. DATE OF DEATH Month Day Year JUNE 3 1968			2b. HOUR 6:45 P M					
3. SEX F			4. RACE White			5. DATE OF BIRTH 9-7-92			6. AGE (In years last birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's			Md.		
10. CITY OR TOWN OF DEATH Forestville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent Nursing Home			12a. USUAL OCCUPATION (Kind of work done during working life, even if retired) OPERN			12b. KIND OF BUSINESS OR INDUSTRY Gov't.					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.			13b. COUNTY DC			13c. CITY OR TOWN Hillcrest Hts			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER 2504 Colebrook Drive.		
14. FATHER'S NAME Carlton P. Shank			First Middle Last			15. MOTHER'S MAIDEN NAME Sarah Palmer			First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES			16b. SOCIAL SECURITY NO 579348768			17. INFORMANT (Brother) Hoy H. Shank			Address 2805 Colebrook Dr. Hillcrest Hts					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-Respiratory Failure 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 170X (b) ADENOCARCINOMA Breast DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days. 9 mo		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ADENOCARCINOMA ARTERIO-SCLEROTIC HEART DISEASE														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from 7/1 , 19 67 , to 6/3 , 19 68 , that (I) (we) last saw the deceased alive on 6/3/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE LEO H. MUGMAN MD			DEGREE MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) LEO H. MUGMAN MD			22e. ADDRESS 2711 GAITHER ST Hillcrest Hts Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6-6-68			23c. NAME OF CEMETERY OR CREMATORY Washington National Cem.			23d. LOCATION (City or Town) (County) (State) Suitland, Maryland					
24. FUNERAL DIRECTOR Wilhelm Funeral Home						ADDRESS 4308 Suitland Rd SE, Suitland, Maryland			25a. REC'D BY REGISTRAR JUN 7 1968			25b. REGISTRAR'S SIGNATURE [Signature]		



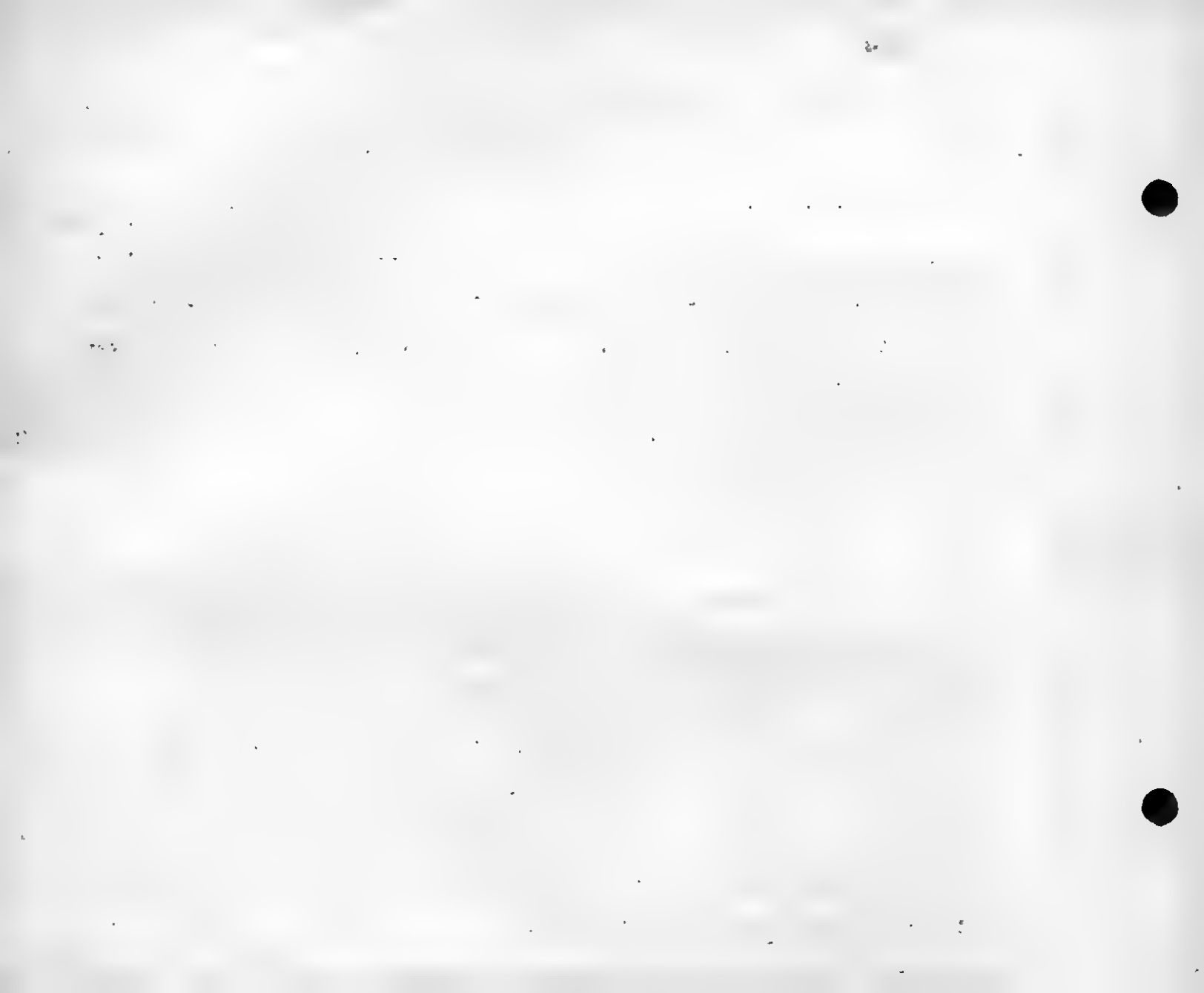
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5711
304 REV 1/48

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) THOMAS WAYNE SHIBLEY			2a. DATE OF DEATH Month 6 Day 2 Year 68		2b. HOUR M
3 SEX Male	4 RACE White	5. DATE OF BIRTH April 6, 1919		6 AGE (in years last birthday) 49 YRS	7 UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Washington D. C.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D. O. A Prince George General		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sheet Metal Worker	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Prince George		13c CITY OR TOWN Landover	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1964 Brightseat Road Apt 201		13f STREET AND NUMBER 201	
14. FATHER'S NAME First George Middle R. Last Shibley		15 MOTHER'S MAIDEN NAME First Helen Middle N. Last Newton			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If in military or naval service) Yes <input checked="" type="checkbox"/> WW II		16b SOCIAL SECURITY NO. 578 16 1872		17 INFORMANT Helen J. Shibley Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 105X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb 26, 1968 , to June 1, 1968 , that (I) (we) last saw the deceased alive on June 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Eugene Cole		22c. DATE SIGNED June 3, 1968		22d. PHYSICIAN'S NAME (Type) Eugene Cole, M. D.	
22e. ADDRESS 639 E. Capitol St. Washington D. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/5/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.					
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03963

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#13a,b,c,d,e. F MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last Hugh Patrick Shields			2a. DATE KNOWN OF DEATH EST. <input type="checkbox"/> Month Day Year MATED <input checked="" type="checkbox"/> 6-4-68 193:00am M			2b. HOUR		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 15 Aug. 1891	6 AGE (In years last birthday) 76 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 6 1 68 19 11:00am M			2d. HOUR
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6000 Bedford Lane			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Retd Printer		12b. KIND OF BUSINESS OR INDUSTRY
13a. U.S.A. RESIDENCE (Where deceased lived if institution residence before admission) STATE Maryland Pa.			13b. COUNTY Prince George's		13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 6000 Bedford Lane			13f. STREET AND NUMBER 2553 S. Shields ST					
14. FATHER'S NAME First Middle Last John Shields			15. MOTHER'S MAIDEN NAME First Middle Last Mary Reilly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Charles E Shields 6000 Bedford Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe MD EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 6-4-68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 8-1968		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Yeadon, Pa.	
24. FUNERAL DIRECTOR Simmons Bros			ADDRESS Wash DC			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. Clemons
26. DATE JUN 6 1968						27. TIME 11:00 AM		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print) Harry P Sipes			2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 6-2-68 1911:31pm			2b HOUR		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 10-18-1925	6 AGE (In years last birthday) 42 YRS	IF UNDER 1 YEAR MONTHS 0	DAYS 3	IF UNDER 24 HRS HOURS 0	MIN 31	2c DATE PRONOUNCED DEAD Month 6 Day 3 Year 1968
7a BIRTHPLACE (State or foreign country) DC		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md		
10 CITY OR TOWN OF DEATH Oxon Hill			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to give street address) 1029 Broadview Road			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic		12b KIND OF BUSINESS OR INDUSTRY
13a USA RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Maryland			13b COUNTY Prince George's			13c CITY OR TOWN Oxon Hill		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME Harry R. Sipes			15 MOTHER'S MAIDEN NAME Jacqueline Warder			13e STREET AND NUMBER 1029 Broadview Road		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS Norma Lee Sipes Same as 13 ABCDE		
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of brain 995X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 119.0								
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 11:30pm 6-2- 1968			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8) Shot in head with 7.65 automatic pistol		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home farm street, factory, office building, etc.) Home			21f LOCATION Street or RFD No City or Town County State same as #13		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 6-4-68		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE June 4-1968			23c NAME OF CEMETERY OR CREMATORY Christ Epis Cemetery		
23d LOCATION (City or Town) (County) (State) Accokeek, Md.			25a REC'D BY REG STRAR Wash DC			25b REGISTRAR'S SIGNATURE John Kehoe MD		
24 FUNERAL DIRECTOR Thomson Bros			ADDRESS Wash DC			DATE JUN 6 1968		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last MARTHA FRANCES SLOAN						2a DATE OF DEATH Month Day Year 6 Month 29 Day 68 Year			2b HOUR 5 P M		
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH 10-16-1885			6. AGE (In years lost birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8-MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md					
1d. CITY OR TOWN OF DEATH HYATTSPVILLE				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Manor 4922 La Salle Rd.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CLERICAL			12b KIND OF BUSINESS OR INDUSTRY U.S. GOVT.	
13a USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE MD.				13b. COUNTY Prince Geor. MT. Rainier		13c INSIDE CITY LIM. TSP? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4028 35th Street			
14 FATHER'S NAME First Middle Last Jeremiah Jerome Burke				15. MOTHER'S MAIDEN NAME First Middle Last Lucy Romine							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO 220-44-453		17 INFORMANT Dr. Elizabeth - 4922 La Salle Rd				Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC HEART DISEASE one week											
4129 DUE TO, OR AS A CONSEQUENCE OF with pulmonary edema											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4206											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from APRIL 5, 1966 , to JUNE 29, 1968 , that (I) (we) lost saw the deceased alive on JUNE 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Thomas F Collins						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED June 29-1968			
22d PHYSICIAN'S NAME (Type) THOMAS F COLLINS				22e ADDRESS 322-A-77NE							
23a BURIAL CREMATION INTERMENT (Specify)		23b DATE 7-3-68		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.			23d LOCATION (City or Town) (County) (State) Colmoa Manor, Md.				
24 FUNERAL DIRECTOR Lee Funeral Home 300-4th Wash. D.C. 20002						25a REC'D BY REGISTRAR JUL - 3 1968		25b REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Creig Patrick Slocombe						ESTIMATED <input checked="" type="checkbox"/> 6-13-68		19 5:00pm		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD		2d. HOUR		
Male	White	1-7-1965	3 YRS			Month 6 Day 13 Year 68		19 5:20pm M.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Wash D. C.		U S A				Prince George's Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Gen. Hospital					-----		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George's		Lanham				9311 Alcona Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Harry G Slocombe			Rebecca J Jenkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
None			None		Harry G Slocombe		same as 13			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Compression of brain</u>										
DUE TO, OR AS A CONSEQUENCE OF <u>Trauma - auto accident</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>820.7</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>8304</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
			5:00pm 6-13-1968		Run over by car.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No		City or Town		County State		
		Driveway of home		same as # 13						
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			6-14-68				
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
Rivendale, Md.			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, or other disposal		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/15/68		Ft. Lincoln Cemetery		Colmar Manor, Maryland				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Francis Gason's Sons 4739 Baltimore Ave. Hyattsville, Md.				DATE JUN 18 1968		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers, pages 4 and 5, to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR 141
3041 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Mary.			First Mary.			Middle Louise			Last Smith			2a. DATE OF DEATH June Month Day Year June 1, 1968			2b. HOUR 1:50AM								
3. SEX Female			4. RACE Colored			5. DATE OF BIRTH Dec. 25, 1895			6. AGE (In years last birthday) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.														
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hosp.						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gen. Housework						12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institut-on Residence before admission) STATE Maryland			13b. COUNTY Prince Geo.			13c. CITY OR TOWN Bowie			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER ---											
14. FATHER'S NAME Robert?			First Robert?			Middle Lee			Last Lee			15. MOTHER'S MAIDEN NAME Maria Wood			First Maria			Middle Wood			Last Wood		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 579-36-5687A			17. INFORMANT Helen Hall - 6th + Chestnut Ave Bowie														
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wenior 112x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO, OR AS A CONSEQUENCE OF (c) ---															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC.)						21f. LOCATION Street or R.F.D. No City or Town County State														
22a. I certify that (I) (the hospital) attended the deceased from May 19, 1968 , to June 1, 1968 , that (I) (we) last saw the deceased alive on May 31, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																							
22b. SIGNATURE A. Bannan-Winn			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 6/1/68														
22d. PHYSICIAN'S NAME (Type) Amir S. Banisar, M.D.			22e. ADDRESS 6323 Landover Rd., Cheverly, Md. 20785																				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE June 5, 1968			23c. NAME OF CEMETERY OR CREMATORY Ebenezer Ch. Cem.						23d. LOCATION (City or Town) (County) (State) Lanham Prince Georges Md.											
24. FUNERAL DIRECTOR H.S. Washington			ADDRESS 4425 Deane Ave NE			25a. RECD BY REGISTRAR DAI JIN			25b. REGISTRAR'S SIGNATURE Charles Young														

FOR STATE
HEALTH DEPT.

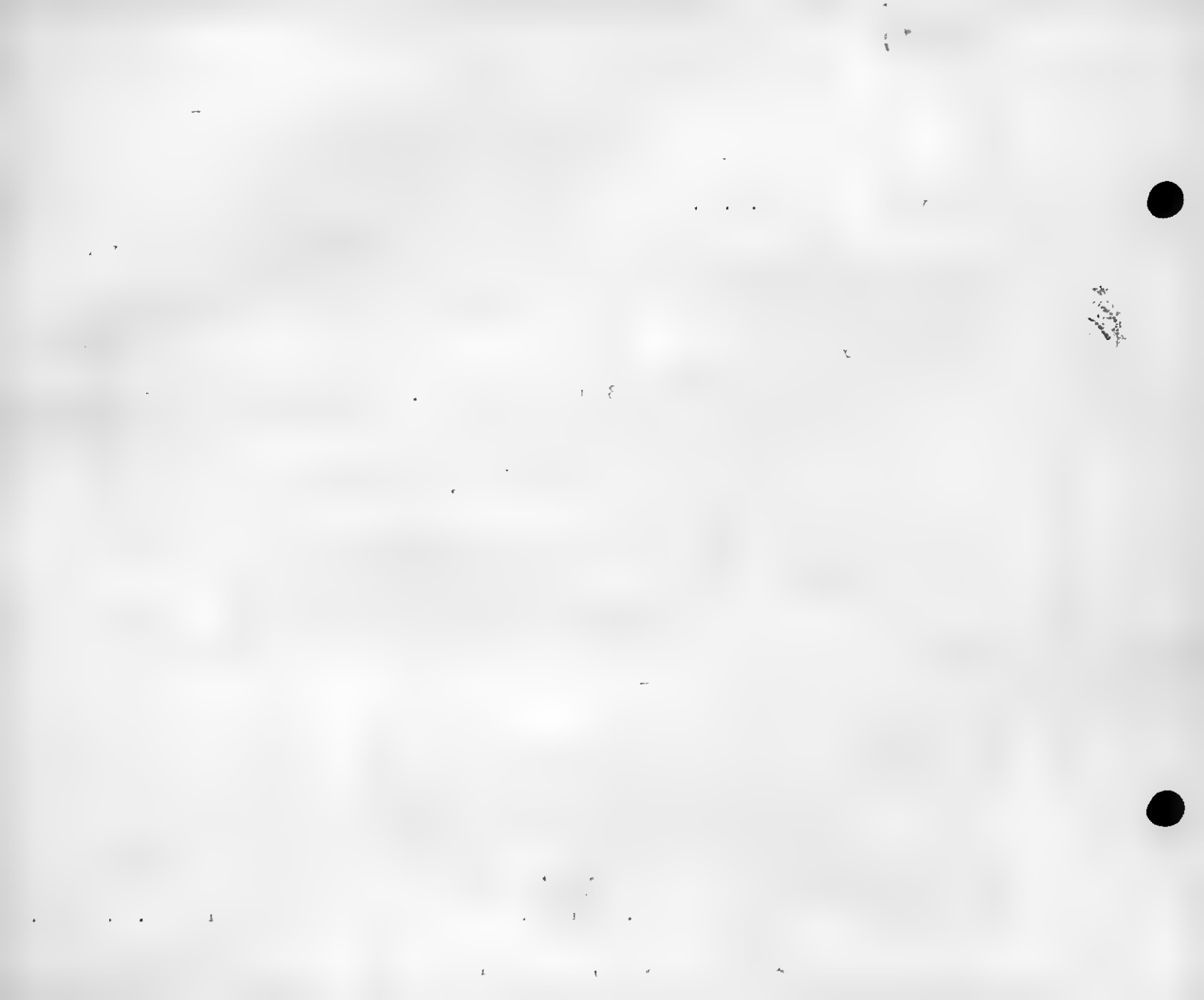
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Lillian G Somner						Month Day Year		05pm		
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2c. DATE PRONOUNCED DEAD		2d. HOUR		
Female	White	6-11-1882	86 YRS			Month Day Year		05pm		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Iowa		U.S.A.				Prince George's		Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during rest of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before)			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland			Prince George's		Landover		YES <input type="checkbox"/> NO <input type="checkbox"/>		2510 Marlboro Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Henry Gilbert			Ellen Griswold							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
no			565 18 3609A		Gilbert R. Somner Same as #13 (son)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple pulmonary emboli										
DUE TO, OR AS A CONSEQUENCE OF Phlebo-thrombosis										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) From immobilization for fracture of right hip/										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Fracture of right hip - 16 days										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH			noon P.M. 5-31- 1968		Fell at home					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
			home		same as # 13					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)			John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6-15-68		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CHURCH OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation			6/18/68		Ft. Lincoln		Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons					Hyattsville, Maryland		DATE JUN 20 1968		J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
William -- Speaks						Month Day Year 6 2 1968		8:20 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
Male		Negro		5/10/1905		63 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
S. C.		U.S.A.				Prince Georges Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Glenn Dale			Glenn Dale Hospital			unknown - Retired		unknown		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
					Wash., D. C.				1322 Fourth St., N. W.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
John -- Speaks			Cary -- Lindsey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
unknown			579-44-8416		Decedent					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebrovascular accident with right cerebral infarction										
4074 DUE TO, OR AS A CONSEQUENCE OF Cerebral arteriosclerosis with right and left focal encephalomalacia										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Generalized arteriosclerosis										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Left pneumonectomy with thoracoplasty, remote (years) for pulmonary tuberculosis; peptic ulcer, active										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21c. LOCATION Street or RFD No City or Town County State				
22a. I certify that xxx (this hospital) attended the deceased from 4/22/1968, to 6/2/1968, that xxx (we) last saw the deceased alive on 6/2/1968, and that in xxx (our) opinion death occurred on the date and hour and from the causes stated above, xxx (we) (did) xxxxxx review the body after death.										
22b. SIGNATURE			22c. DATE SIGNED							
Moe Weiss			6/2/1968							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
Moe Weiss, M. D.			Glenn Dale Hospital Glenn Dale, Maryland							
23a. BURIAL, CREMATION, RESURRECTION, ETC.		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6-7-68		Hannany Cemetery		Landover Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Doris D. Watson			3435-14th St			JUN 4 1968		Charles Judge		



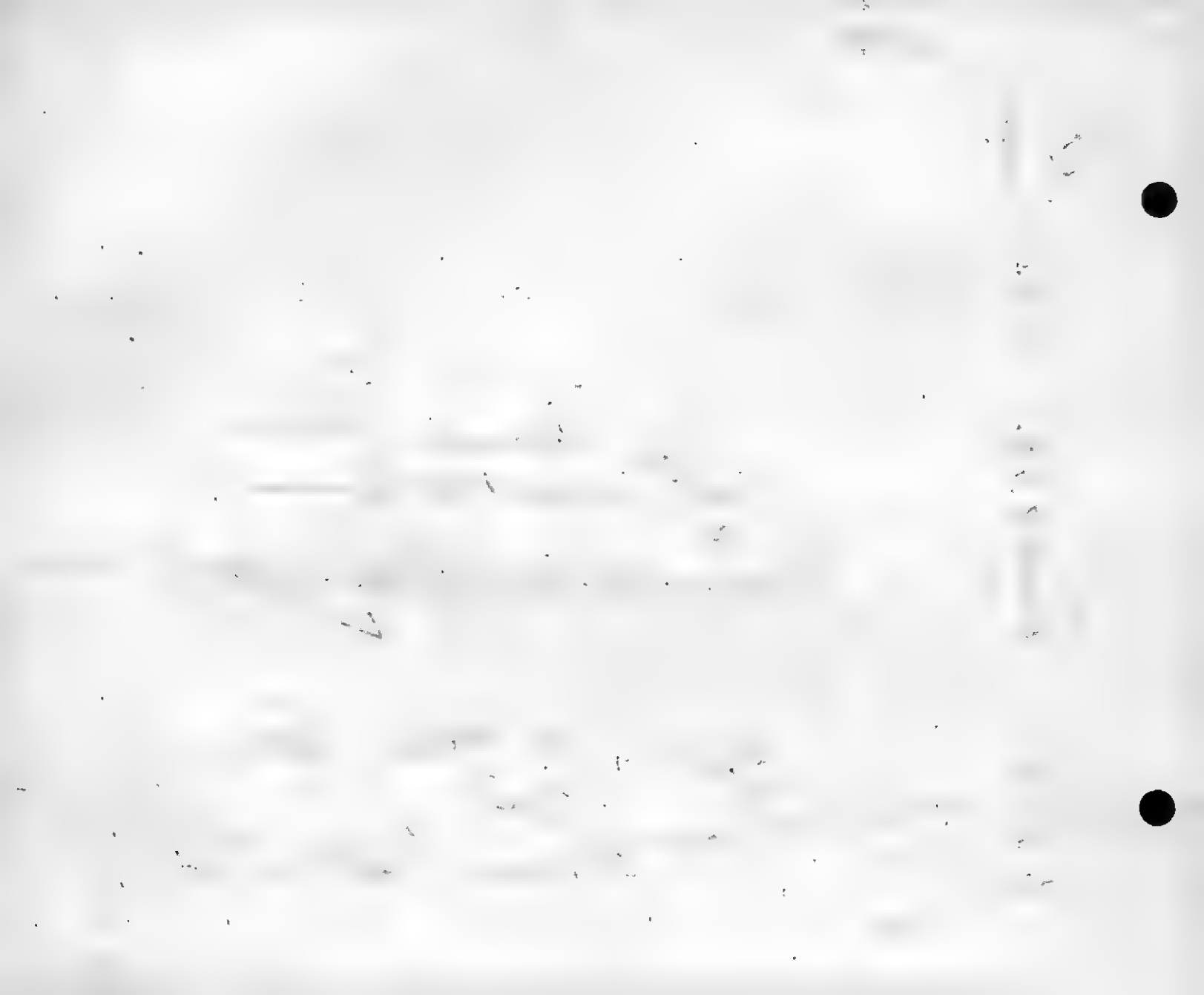
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Medicine Dept. Noted 3:30 pm - 9-2-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Everett V Staley			2a. DATE OF DEATH Month 6 Day 28 Year 68		2b. HOUR 2:30 M
3 SEX Male	4 RACE White	5. DATE OF BIRTH 12/8/1890		6 AGE (In years last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Illinois	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md	
10 CITY OR TOWN OF DEATH Riverdale	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hos.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Owner		12b KIND OF BUSINESS OR INDUSTRY Automobile co
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Prince Geo.	13c CITY OR TOWN Hyattsville	13d INS OF CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 3605 Jefferson St.
14 FATHER'S NAME First Middle Last William Everett		15. MOTHER'S MAIDEN NAME First Middle Last Lucy Larison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If yes, give year or dates of service)		16b SOCIAL SECURITY NO 213-01-1920		17. INFORMANT Louise C Staley Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4127 Sudden Myocardial Failure IMMEDIATE CAUSE (a) Sudden Myocardial Failure DUE TO OR AS A CONSEQUENCE OF Surgical neck laceration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Sudden Myocardial Failure DUE TO OR AS A CONSEQUENCE OF Surgical neck laceration					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4127 Sudden Myocardial Failure					
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from June 17, 1960 to June 27, 1968 , that (I) (we) last saw the deceased alive on June 27, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE W.L. Etienne		22c. DATE SIGNED 6/28/68		22d PHYSICIAN'S NAME (Type) W.L. Etienne	
23a BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b DATE July 2, 1968	23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR JUL - 2 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

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1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Hazel S. Stinchcomb						6 14 68			8:45		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
FEMALE		White		1/3/11		57 yrs					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA.				Prince George's Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.)		12b. KIND OF BUSINESS OR INDUSTRY					
Riverdale		Leland Memorial		homemaker		Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Pennsylvania		Armstrong		Adrian		YES		RFD 1 Adrian Pa.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Ulysses G. Donaldson Sr.						Emma E. Sinsky					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address		
no						Theodore R. Stinchcomb			Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION										SUDDEN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AORTIC STENOSIS										UNKNOWN	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 5 JUNE, 1968, to 14 JUNE, 1968, that (I) (we) lost saw the deceased alive on 14 JUNE, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE C. J. Houmann				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 14 JUNE 1968			
22d. PHYSICIAN'S NAME (Type) C. J. HOUMANN M.D.				22e. ADDRESS RIVERDALE MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City or Town)		(County)		(State)	
Burial		6/18/68		St. John's Church		Beltsville		P.G.		Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons				Hyattsville, Maryland		DATE JUN 20 1968		Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) MARGARET EILEEN STONE			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 6 Day 20 Year 1968			2b HOUR 7:30 AM			
3 SEX F	4 RACE W	5 DATE OF BIRTH Nov 17 1944	6 AGE (in years last birthday) 53 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0		2c DATE PRONOUNCED DEAD Month 6 Day 30 Year 1968	2d HOUR 8:00 AM
7a BIRTHPLACE (State or foreign country) Otherland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Pr Geo			
10 CITY OR TOWN OF DEATH Powdermill		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calverton Naval Air Station			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md		13b COUNTY Pr Geo		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 4236 Powdermill Rd	
14. FATHER'S NAME First Patrick R Middle Yragon Last Daugherty			15 MOTHER'S MAIDEN NAME First Margaret Middle Daugherty Last Daugherty						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon monoxide poisoning DUE TO, OR AS A CONSEQUENCE OF Smoke inhalation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Smoke inhalation DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month June Day 20 Year 1968 HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18) Fire occurred in home					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or RFD No. 4236 Powdermill Rd City or Town Bethesda County Pr Geo State Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Dayton Watkins		EXAMINER'S NAME (Type) DAYTON D WATKINS		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 7-1-68			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 7-3-1968		23c NAME OF CEMETERY OR CREMATORY Mary Rest Cemetery		23d LOCATION (City or Town) (County) (State) Darlington, New Jersey			
24 FUNERAL DIRECTOR Nalley Funeral Home Mt. Rainier, Md.				ADDRESS		25a REC'D BY REGISTRAR JUL - 8 1968		25b REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Helen	Middle --	Last Thomas	2a. DATE OF DEATH Month June Day 23 Year 1968		2b. HOUR 3:20 P.M.
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 2/20/1887		6. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unknown - retired		12b. KIND OF BUSINESS OR INDUSTRY unknown	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY Wash., D.C.		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 15th & Park Rd., N. W.	
14. FATHER'S NAME First Arthur Middle -- Last Hammon		15. MOTHER'S MAIDEN NAME First Rebecca Middle -- Last Sawyer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Decedent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction (clinical) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive & arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic renal disease; chronic brain syndrome.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DIRECT CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (this hospital) attended the deceased from 4/19/1968 to 6/23/1968 , that we (we) last saw the deceased alive on 6/23/1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above and (we) (did) not view the body after death.							
22b. SIGNATURE Moe Weiss				22c. DATE SIGNED 6/23/1968			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-28-68		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION (City or Town) (County) (State) Md.	
24. FUNERAL DIRECTOR Thomas A. Carter & Co. Inc.				25a. REC'D BY REGISTRAR JUL - 1 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-113. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15M
10M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input type="checkbox"/> Month	<input type="checkbox"/> Day	<input type="checkbox"/> Year	2b. HOUR
Nellie Frances Thompson						6-5-68			195			4:00pm
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR		
Female	White	4 May 1882	86 YRS	MONTHS	DAYS	HOURS	MIN.	Month	Day	Year	5:15pm	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Beaver County, Pa.		USA				Prince George's Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale			Leland Memorial Hospital			Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland			Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>		5008 37th Avenue				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
? Martin						Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			None			Howard Elder			5008 37th St. West Hyattsville Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Heart failure												
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)						
			HOUR A.M. P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town			
									County			
									State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
22a. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE			John Kehoe MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			John Kehoe MD			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			6-6-68			
			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			6/8/68			Parkwood Cemetery			Baltimore, Maryland			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
John A. Moran, Inc.			3000 E. Baltimore St.			DATE JUN 10 1968						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Augusta		First Middle Last W. Townshend		2a. DATE OF DEATH Month Day Year June 2 1968		2b. HOUR 9:30 PM	
3. SEX F		4. RACE Caucasian		5. DATE OF BIRTH 10-21-1882		6. AGE (in years last birthday) 85 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. George	
10. CITY OR TOWN OF DEATH Clinton, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Pr. Charles		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last George S. Harrison		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Browning		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO MA-275848	
17. INFORMANT M. Hart, RN.		Address 5945 Fisher Rd. Oxon Hill, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) ARTERIOSCLEROSIS		(c) SENILE SYNDROME		17 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 CANCER OF THE PANCREAS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-11 1968 to 6-3 1968 , that (I) (we) lost saw the deceased alive on 6-3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Alfred R. Lippman		22c. DATE SIGNED 6-3-68		22d. PHYSICIAN'S NAME (Type) ALFRED R. LIPPMAN, MD		22e. ADDRESS CLINTON, MD	
23a. BURIAL, CREMATION, ETC. (Type) BURIAL		23b. DATE 6/6/1968		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Methodist		23d. LOCATION (City or Town) (County) (State) Cemetery, Cheltenham, Md.	
24. FUNERAL DIRECTOR Michael Funeral Home, Inc. La Plata, Md.		ADDRESS		25a. REC'D BY REGISTRAR JUN 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Walter C Troup			2a DATE OF DEATH Month 6 Day 14 Year 1968			2b HOUR 1 P.M.					
3 SEX Male		4 RACE White		5. DATE OF BIRTH 7-12-1895		6. AGE (In years last birthday) 72 YRS		IF UNDER 1 YEAR MONTHS 1 DAYS 1		IF UNDER 24 HRS. HOURS 1 MIN.	
7a BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.					
1d. CITY OR TOWN OF DEATH Adelphi		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3130 Powder Mill Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Engineering Research				12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Riverdale		13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5309 Taylor Rd.			
14. FATHER'S NAME First James Middle Jacob Last Troup				15 MOTHER'S MAIDEN NAME First Bertha Middle B. Last McCabe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b SOCIAL SECURITY NO. 216-22-0783		17 INFORMANT Address Della Troup-5309 Taylor Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure & shock 440.9 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic liver - general DUE TO, OR AS A CONSEQUENCE OF (c) 15x11.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4.00											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5-15-1968 to 6-14-1968 , that (I) (we) lost saw the deceased alive on 6-14-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE R.D. Banner		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-14-68							
22d. PHYSICIAN'S NAME (Type) R.D. Banner M.D.		22e ADDRESS 2513 Buckridge Rd. Adelphi, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE June 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Edwardsport Cemetery		23d LOCATION (City or Town) (County) (State) Sandborn Indiana					
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 18 1968			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Pauline Rose Walthall						June 6, 1968			9:17A ^M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		1. UNDER 24 HRS.	
Female		Caucasian		Jan. 4, 1900		68 YRS.		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Germany		U S A				Prince George's		Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince Geo. Gen'l Hospital		Sales Lady		Bakery					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Prince George's		Cheverly				5807 Landover Rd.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S M.A.DEN NAME		First Middle Last	
Frederick				Winkler				Sophie		Weasease	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		None		577 16 5225		William O Walthall		Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute bacterial endocarditis, staphylococcal of the											
DUE TO, OR AS A CONSEQUENCE OF (b) mitral valve										six weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4/100											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:(a)											
Purulent pericarditis. Terminal pneumonia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
				4/25, 1968 to June 6, 1968							
22a. I certify that (I) the hospital attended the deceased from June 6, 1968, and that in (my) (xxx) opinion death occurred on the date and hour and from the causes stated above, (I) (xxx) (did) (xxx) view the body after death.											
22b. SIGNATURE		Frederick H. Wilhelm				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/6/68			
22d. PHYSICIAN'S NAME (Type)		Frederick H. Wilhelm, M. D.				22e. ADDRESS 6319 Landover Road, Cheverly, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		June 8 1968		Ft. Lincoln Cemetery		Colmar Manor, Maryland					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Nalley Funeral Home Mt. Rainier, Md.						DATE JUN 10 1968		Charles Judge			

FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) William O. Ward			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year 6-10-68 191:00pm			2b. HOUR		
3 SEX Male	4. RACE White	5. DATE OF BIRTH 1-28-1937	6 AGE (In years last birthday) 31 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 6 10 68 191:00pm M		
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CIT ZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Leland Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Automotive		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Monrovia		13d. INSIDE CITY (J.M.T.S?) YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 54
14. FATHER'S NAME First Middle Last Arthur W. Ward			15. MOTHER'S MAIDEN NAME First Middle Last Alice Marie Tenney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give year or dates of service) 1955-1958		16b. SOCIAL SECURITY NO 232 60 1576		17 INFORMANT ADDRESS Mrs. Patricia Ward, Monrovia, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LACERATION OF BRAIN DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) TRAUMA - BRAIN-CHAIR COLLISION DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8110								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 8:40pm 6-3- 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of truck which was struck by a train.				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Railroad Crossing, Annandale Rd. & Rt. 1, Beltsville, Md.		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John F. Echhoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-11-68
EXAMINER'S NAME (Type) John Echhoe MD		Rivendale, Md.		ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 11, 1968		23c. NAME OF CEMETERY OR CREMATORY Bush Creek Cemetery		23d. LOCATION (City or Town) Monrovia		(County) Frederick (State) Md.
24. FUNERAL DIRECTOR Donald M. Fitchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE JUN 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

08586

1. DECEASED NAME (Type or print) Virginia			First Middle Lost WAUGH			2a. DATE OF DEATH Month Day Year May June 2, 1968			2b. HOUR 7 A M		
3. SEX female			4. RACE white			5. DATE OF BIRTH Nov. 16, 1927			6. AGE (In years lost birthday) 40 YRS		
7a. BIRTHPLACE (State or foreign country) Kent Co. Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. Separated <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George Md		
10. CITY OR TOWN OF DEATH Cedarville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mobile Park At home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Practical Nurse			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland			13b. COUNTY P. Geo.			13c. CITY OR TOWN Cedarville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 1319 (13th St.)			14. FATHER'S NAME First Middle Lost Edgar P. Moffett			15. MOTHER'S MAIDEN NAME First Middle Lost Cora L. Schutt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO 579 30 7384			17. INFORMANT Edgar Moffett			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of brain DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1968 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 2 mos											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ANOREXIA, MALNUTRITION, ANEMIA.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JAN 2, 1968 to DEATH , that (I) (we) last saw the deceased alive on MAY 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert W. Merkle						DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. <input type="checkbox"/>			22c. DATE SIGNED JUNE 2, 1968		
22d. PHYSICIAN'S NAME (Type) Robert W. Merkle						22e. ADDRESS Clinton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6/5/68			23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery			23d. LOCATION (City or Town) (County) (State) Galena, Md.		
24. FUNERAL DIRECTOR Wells Wells						ADDRESS Chestertown, Md.			25a. REC'D BY REGISTRAR DATE JUN 6 1968		
						25b. REGISTRAR'S SIGNATURE Charles J. J...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it from pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
2 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
Jennie			Weiss			6 Month 23 Day 68 Year		1135 M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		W		12/31/84		63 84 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Hungary		U.S.				Prince George		Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USLA OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Lanham, Md.		Maggie's		Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MD		P.G.		Baltimore				5800 ANNAPOLIS RD	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
UNKNOWN			UNKNOWN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
No		UNKNOWN		S.L. ROSENBERG		348 S. RIVER ST. WILKES BARRE, PA.			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Septicemia</u>								10 days	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								2 weeks	
(b) <u>Osteomyelitis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Diabetes Mellitus</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		P.M. 19							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> , to <u>23 June</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>23 June</u> , 19 <u>68</u> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED							
Wm. A. Wimsatt MD		23 June 1968							
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
Wm. A. Wimsatt, MD		3415 HAMILTON ST. HYATTSVILLE, MD.							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		6-25-68		OHAVEZDEK CEM		HALLVETSP LUTHERS PA			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REG. STRA'S SIGNATURE			
Solomon Funeral Home		4217-9th St. W.		DATE JUN 25 1968		J. Charles Judge			

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) KENNETH CARTER WHITE			2a. DATE OF DEATH 6 Month 7 Day 1968			2b. HOUR 6:52 P.M.			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 9/9/1896		6. AGE (In years lost birthday) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.			
10. CITY OR TOWN OF DEATH CLINTON, MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PRINCE GEORGE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY CHARLES		13c. CITY OR TOWN Cobb Island		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last EDGAR B. White			15. MOTHER'S MAIDEN NAME First Middle Last Addie BUTLER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service.) Yes - NAVY - TOTAL 3 mos.			16b. SOCIAL SECURITY NO 578-05-9621		17. INFORMANT Address James B. Simms, Cobb Island, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) CIRCULATORY COLLAPSE 3-DAY									
DUE TO, OR AS A CONSEQUENCE OF									
(c) CARCINOMA LUNG (LEFT) 6 mo									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>JUNE 7, 1968</u> , that (I) (we) last saw the deceased alive on <u>JUNE 7, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alfred R. Lapin, MD				22c. DATE SIGNED 6-7-68					
22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD				22e. ADDRESS CLINTON, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE June 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Prince George, Md			
24. FUNERAL DIRECTOR ADDRESS Anchor Funeral Home, Inc. La Plata, Md				25a. REC'D BY REGISTRAR DATE JUN 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Leadora			First M	Middle White	Last	2a. DATE OF DEATH Month June Day 27 Year 1968	2b HOUR 8:15A
3 SEX Female	4 RACE Negro	5. DATE OF BIRTH 1/1/1928		6 AGE (In years last birthday) 40	7 UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Va.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges		Md		
10 CITY OR TOWN OF DEATH Glenn Dale		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk		12b KIND OF BUSINESS OR INDUSTRY unknown	
13a USJAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b COUNTY ✓	13c CITY OR TOWN Wash., D. C.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 1358 Columbia Rd., N. W.		
14. FATHER'S NAME First Walter Middle -- Last Baber			15 MOTHER'S MAIDEN NAME First Ellen Middle -- Last Gordon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b SOCIAL SECURITY NO 232-23-2303		17. INFORMANT Address Decedent			
18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Possible myocardial infarction (clinical) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 4201 (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Pulmonary tuberculosis, far advanced.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (a) (this hospital) attended the deceased from 6/24/1968 , to 6/27/1968 , that (b) (we) last saw the deceased alive on 6/27/1968 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did not) view the body after death.							
22b SIGNATURE Moe Weiss				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 6/27/1968	
22d PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22e ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 6-30-68		23c NAME OF CEMETERY OR CREMATORY CHURCH Cemetery		23d LOCATION (City or Town) (County) (State) Arlington Va	
24 FUNERAL DIRECTOR John T. RHINES & Co. 3015 72nd ST. N.E.				ADDRESS WASH., D.C.		25a REC'D BY REGISTRAR JUL - 8 1968	
				25b REGISTRAR'S SIGNATURE John T. Rhines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEANED WITH MEDICAL EXAMINER DR. BERDOVITZ

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

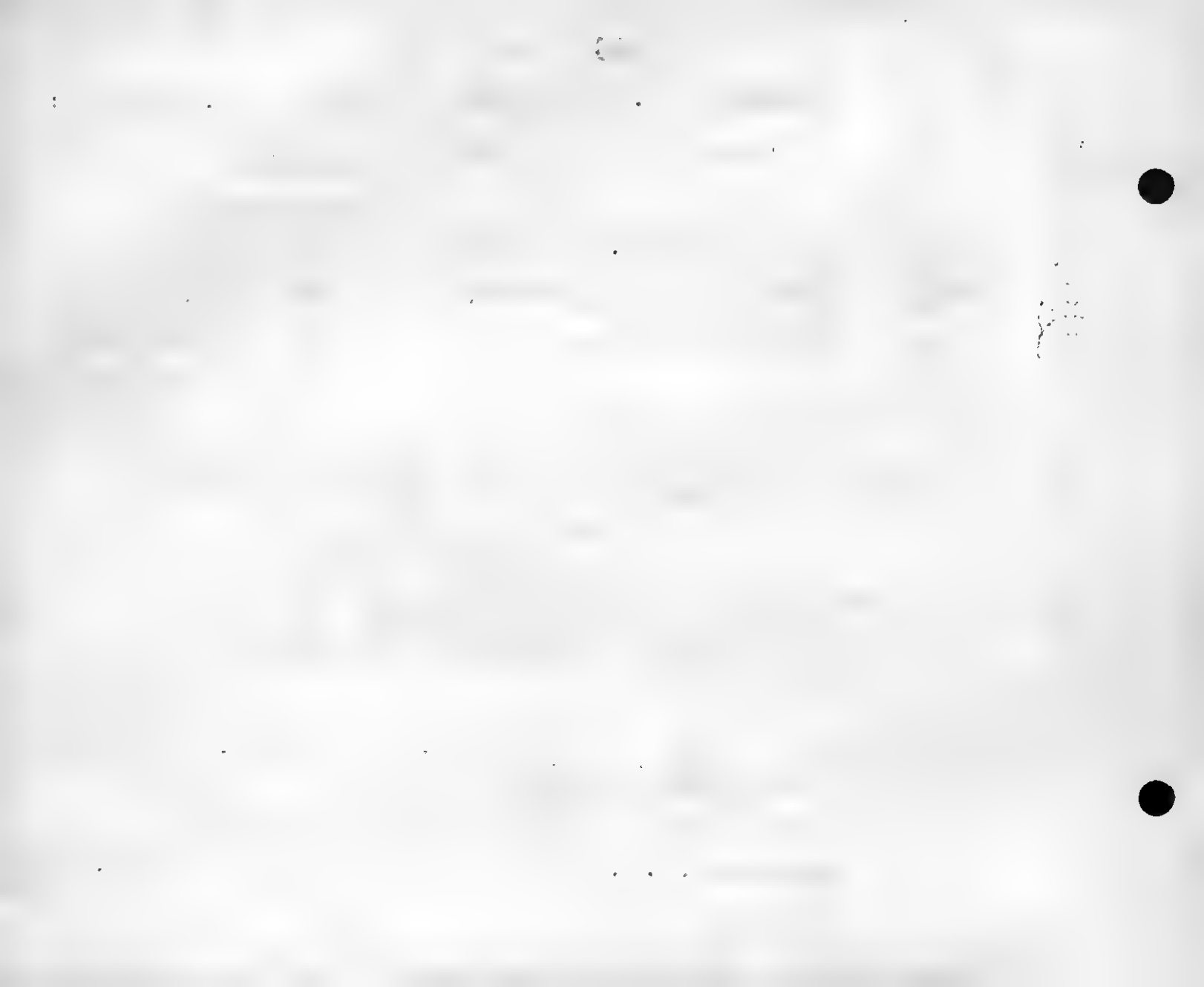
1. DECEASED-NAME (Type or print) Bertha NMI Wicks			2a. DATE OF DEATH Month 6 Day 5 Year 68			2b. HOUR 9:45 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4/17/93		6. AGE (In years lost birthday) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Hungary		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md					
10. CITY OR TOWN OF DEATH Takoma Park Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7804 Kennitzwick Ave. TK			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince Georges			13c. CITY OR TOWN Tk Pk		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7804 Kennitzwick Ave. TkPK	
14. FATHER'S NAME Samuel Shaffer			15. MOTHER'S MAIDEN NAME Paula ? ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown none			16b. SOCIAL SECURITY NO UNKNOWN			17. INFORMANT husb. Adolfa 7804 Kennitzwick Ave. Tk Pk.Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 15 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) HYPERTENSION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/29/59 to 6/5/68, that (I) (we) last saw the deceased alive on 6/5/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (do not) view the body after death.											
22b. SIGNATURE David Goldenberg			22c. DATE SIGNED 6/5/68			22d. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG			22e. ADDRESS 9801 GEORGIA SILVER SPRING, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 6/6/68			23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. Cem.			23d. LOCATION (City or Town) (County) (State) HYATTSVILLE, MD.		
24. FUNERAL DIRECTOR GOLDENBERG FUNERAL HOME 42179 MTN. U.			25a. REC'D BY REGISTRAR DATE JUN 7 1968			25b. REGISTRAR'S SIGNATURE Charles Young					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23a, Film 0401 6/24/68 km 1										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										6/24/68 km 1										CERTIFICATE OF DEATH										31																			
1 DECEASED NAME (Type or print)										First Middle Last										2a DATE OF DEATH Month Day Year										2b HOUR P																													
Frederick										E. Wilkinson										June 11, 1968										3:35 PM																													
3. SEX										4 RACE										5. DATE OF BIRTH										6 AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
Male										Caucasian Negro										10/20/16										51 YRS.																													
7a BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH																													
Md										USA																				Prince George's Md																													
10. CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																													
Cheverly										Prince Geo. Gen'l Hospital										Truck driver																																							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b COUNTY										13c. CITY OR TOWN										13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
District of Columbia																				Washington, NE																				6421 K Street																			
14 FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																													
Eugene										W. Wilkinson										Vernell										Livingston																													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										(If yes give war or dates of service)										16b. SOCIAL SECURITY NO										17. INFORMANT										Address																			
																														Naomi minor - Sister - 3451 - Massena St																													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										CREBRAL HEMORRHAGE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
4210										DUE TO, OR AS A CONSEQUENCE OF																				2 days																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b)										Hypertensive Cerebral Vascular Disease										5 years																													
										(c)										Hypertension										10 years																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										SEX																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that xx (this hospital) attended the deceased from June 10, 1968, to June 11, 1968, that he (we) lost saw the deceased alive on June 11, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (d did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>										22c. DATE, SIGNED																													
																														6/11/68																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
Leonard Appel, M. D.										Prince George's General Hospital, Cheverly																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) Maryland																													
Buried										6-15-68										Harmony										Highland Park Md																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
																				DATE JUN 18 1968										Charles Judge																													



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print) Gordon		First		Middle N.M.N.		Last Williams		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> June 24 1968		2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH Feb. 23, 1897		6 AGE (In years last birthday) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 		2c DATE PRONOUNCED DEAD Month June Day 24 Year 1968		2d HOUR M
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges		Md		
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b COUNTY Prince Georges		13c CITY OR TOWN		13d INSIDE CITY, HTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 2301-57th Place		
14. FATHER'S NAME First Emmanuel		Middle 		Last Williams		15 MOTHER'S MAIDEN NAME First MARY		Middle 		Last McCall
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes-no, or unknown) YES		(If yes give war or dates of service) WWI		16b SOCIAL SECURITY NO 108-07-5254		17. INFORMANT Mary Williams		ADDRESS Same as # 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema Two months DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Generalized DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4 years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Dayton O WATKINS		EXAMINER'S NAME (Type) DAYTON O WATKINS		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5318 Campbell Rd ADDRESS (Street, city, town, or county) Bearingsbury Pk		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/29/68		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION (City or Town) Palmerton		(County) 		(State) Pa.
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland						25a REC'D BY REGISTRAR JUL - 2 1968		25b REGISTRAR'S SIGNATURE J Charles Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or Print) THOMAS C WILLIAMS						2a DATE KNOWN OF DEATH Month 6 Day 27 Year 1968		2b HOUR M					
3 SEX M		4 RACE W		5 DATE OF BIRTH Sept. 16, 1878		6 AGE (in years) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign) Wales			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Prince George				
10 CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL OR HOME (If not in hospital give street address) Prince George General				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ref. Civil Engineer			12b KIND OF BUSINESS OR INDUSTRY Self		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b. COUNTY P. G.				13c CITY OR TOWN Greenbelt		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 159 Westway Road	
14. FATHER'S NAME First Charles Middle Williams Last Williams						15. MOTHER'S MAIDEN NAME First Mary Ann Middle Powell Last Powell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b SOCIAL SECURITY NO (If yes give war or dates of service)				17 INFORMANT Thomas W. Williams				ADDRESS Washington D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Edema 400x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia - arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) fracture Hip.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Subject fell & injured Hip					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Dayton O Watkins M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) DAYTON O WATKINS						22b DATE SIGNED 6-27-68							
23a BURIAL, CREMATION, OR OTHER DISPOSITION Burial						23b DATE 6/29/68		23c NAME OF CEMETERY OR CREMATORY Washington National					
24 FUNERAL DIRECTOR Francis Gasch's Sons						ADDRESS Hyattsville, Md.		25a REC'D BY REG STRAR JUL - 2 1968		25b REGISTRAR'S SIGNATURE Charles Judge			
23d LOCATION (City or Town) (County) (State) Suitland P.G. Md.													

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED			Month Day Year			2b. HOUR		
Vincent L. Williams						6 18 19 68			5:30					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
M	Negro	Unknown	39 YRS					Month Day Year			5:30 M			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
		US				Prince George Md								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George			unemployed								
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Ma			Prince George Tuxedo						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1702 Kenilworth Ave.		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last										
unknown														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>intra cerebral hemorrhage</u>											2 days			
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
			19 P.M.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			John Kehoe, M.D., Riverdale			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			6-24-68					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)								
		6/26/68		Ansony Road, 4, 0, M.D.										
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
						JUL - 2 1968		J. Charles Judge						

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR 4922 KASALLE RD</u>		d. STREET ADDRESS <u>9803 WILLOWOOD RD</u>	
3. NAME OF DECEASED (Type or print) First <u>SUSIE</u> Middle <u>C.</u> Last <u>WITHERS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>AUG 7 - 1882</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PATRICK A. BROSNAN</u>		14. MOTHER'S MAIDEN NAME <u>ELLA HARMON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-46-5005</u>	
17. INFORMANT <u>SON - JOSEPH WITHERS</u>		Address <u>618 ROLLINS AVE ROCKVILLE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4129</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia secondary to Arteriosclerotic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>June 14, 1968</u> , to <u>June 24, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 23, 1968</u> , and that death occurred at <u>12:10</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F Collins</u>		22b. DATE SIGNED <u>June 24, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas F Collins, M.D.</u>		22d. ADDRESS <u>322 H St. N.E. Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-26-68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>COLUMBIA GARDENS CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VA.</u>	
24. FUNERAL DIRECTOR <u>James E. D'Silva</u>		25a. REC'D BY REGISTRAR <u>JUL - 1 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>2222 Wisc. Ave, N.W. Wash. D.C.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
Item#22a, FilmG102 7/17/68 km									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
GUST JOHN YANDALA						June 23, 1968		1320M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		March 9, 1915		53 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Pennsylvania		USA				Prince George's County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Andrews AFB		Malcolm Grow USAF Hospital		USAF		Military			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Virginia		Fairfax		Fairfax		YES		8502 Crestview Drive	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Gust (NMI) Yandala			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT (wife)		Address		
yes			278 - 36 - 2815		Jeanne Yandala		8502 Crestview, Fairfax, Va		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>427.2</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>433.0</u> (b) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma of lung, carcinoma of kidney, polymyositis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>15 April</u> , 19 <u>68</u> , to <u>23 June</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>23 April</u> , 19 <u>68</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (the not) view the body after death.									
22b. SIGNATURE <u>William E. Palma, Capt USAF MC</u>				22c. DATE SIGNED <u>23 June 68</u>					
22d. PHYSICIAN'S NAME (Type) WILLIAM E. PALMA, CAPT, USAF MC				22e. ADDRESS MALCOLM GROW USAF HOSP. MD.		ANDREWS AFB,			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/26/68		Arlington National Cem. Arlington, Virginia					
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Falls Church Funeral Home, Falls Church, Va				JUN 26 1968		J Charles Judge			

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James Earl Ray

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Designated TADP was 1100544.

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202 - 36 - 2112 Bureau of Land Management, 1800 Broadway, Seattle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08997

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Ida Mae Young						June 12, 1968			10:40 A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Caucasian		Oct. 30, 1927		40 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Virginia		U.S.A.				Prince George's					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Prince George's Hyattsville					7510 Forest Rd.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Jack Taylor			Harriet E. Wyantt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			579 34 6807			John A. Young			Same as #13 (husband)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the left main stem bronchus with</u> <u>metastasis to opposite lung, regional</u> <u>nodes, pericardium and diaphragm.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchopneumonia - bilateral.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchopneumonia - bilateral.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cancer of the cervix, radiated.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) examined attended the deceased from <u>1965</u> , 19 <u> </u> , to <u>June 12</u> , 19 <u>68</u> , that (I) was last saw the deceased alive on <u>June 12</u> , 19 <u>68</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) view view the body after death.											
22b. SIGNATURE <u>Benjamin Miller</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
								June 13, 1968			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Benjamin Miller, M. D.						3824 34th St., Mt. Rainier, Maryland 20822					
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6/15/58		Elk Run		Elkton		Va.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.						JUN 17 1968		<u>Francis Gasch</u>			

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